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Clinical supervision in mental health: A Foucauldian discourse analysis

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Summary

The practice of clinical supervision amongst mental health practitioners is hampered by a lack of shared understanding of its nature and purpose and by a complex mixture of assumptions and external expectations. As a result, potential benefits of supervision are diminished and its practice risks losing credibility amongst those in a position to resource it. This study addresses these conflicts through an analysis of the discourse of supervision within mental health nursing, counselling and clinical psychology.

Analysis of both policy and academic literature enabled the identification of three dominant discourses of supervision: supervision as *containment*, as *development* and as *safeguard*.

The roots and history of each discourse were explored and a *discursive frame* for supervision constructed. This discursive frame was then applied to data collected through interviews with supervisors and supervisees as well as real supervision sessions, in order to identify ways in which participants drew from these dominant discourses.

Application of Foucault's approach to discourse analysis problematises the data through the method of identifying implicit rules governing what can and cannot be said about the nature and practice of supervision.

Analysis suggests that these dominant discourses continue to inform the nature and practice of supervision, but that each of them is problematic in its own way.

Nonetheless, practitioners draw from them in resourceful ways through a process of

active meaning-making, creating the possibility of positive outcomes for themselves and for those with whom they work.

A new discourse related to the nourishing potential of supervision on practice is identified and a new framework for supervision proposed. This framework has the potential to facilitate meaningful and productive supervision for practitioners in a wide range of contexts while remaining responsive to changing and competing external expectations.

Chapter one: A reflexive introduction

It was a chance remark in a casual conversation that became the motivation to undertake this study. Sitting with a group of fellow counsellors, I happened to ask the question, '*if we weren't obliged to engage in supervision* [as part of the counselling code of ethics and practice], *would we bother?*'

I wasn't entirely surprised by the answer: a categorical affirmation of the inherent value of supervision and the strongly worded assertion that it would be sought out even if not mandated. But the very speed and forcefulness with which it was asserted took me aback. It caused me to wonder why the benefits of supervision, at least within counselling, seemed to have attained the status of a 'given'. I wondered what that revealed about the way in which the relatively recent emergence of counselling as a 'profession' (at least an aspiring one – with the recognisable characteristics of an established profession: a professional body, a code of ethics, an accreditation and regulatory process - see the section on the changing nature of the professional on page 92) had so quickly established supervision as a core, and mandatory, aspect of its practice. I was also somewhat concerned as to the extent of the resistance expressed even to my asking the question. The fact that most counsellors work either in private practice or in the voluntary sector means that they often personally bear the, not insubstantial, cost of supervision. And the more counselling hours practised, the more supervision is required. So it did not seem unreasonable to suggest that it would be worth reviewing the value of the considerable investment the practice of supervision required. This is why the answer surprised me.

It is the fact that my interest in supervision as a topic for research was triggered by a conversation that caused me to reflect on the potential of conversation and discourse

as a means of meaning-making. Not until I had asked that question and been impacted by the answer, did it acquire the nature of an issue to be researched. It was in the discourse that the topic itself was created. So it seemed only appropriate to explore discursive research methodologies.

But the starting point itself proved an immediate challenge. It is clear to anyone involved in the practice of supervision that the term itself is problematic. The most familiar context within which it is used is in respect of the oversight of someone's work. Workplaces have supervisors, whose responsibility is to ensure that the workforce undertakes its tasks effectively, and to whom the workforce is accountable. From factory floors to local authority social work teams, this kind of supervision is visible and recognisable.

A secondary, but widespread, context in which the term is used is in the supervision of academic work. Every student who has ever undertaken a dissertation of any sort will have been assigned a supervisor, someone who has some expertise in the area of interest and can guide, oversee and sometimes also assess the student's work.

Unfortunately, both these contexts are unhelpful when trying to communicate what is meant by supervision in counselling. Almost every text book written on the subject attempts to reiterate a distinct meaning and several will be referenced in this thesis. Broadly speaking, the accepted meaning of supervision for a counsellor concerns a one-to-one conversation with another counsellor, almost always one with more experience in counselling, with whom individual clients are discussed. The supervisee would expect to meet up with their supervisor approximately once a month for an hour or two and would expect to come away from this conversation with some new ideas for ways of working with their clients. Of course, with every detail of this most basic definition, there are variations and preferences and therein lies the

first of many problems with any attempt to reach a consensus on what constitutes supervision. Even more reason, then, to ensure there is always the space to ask the basic questions. If supervision is so critical to the practice of counselling, why is it so difficult even to identify exactly what it is? What exactly is it that is so critical that we would pay for it even if we weren't required to? What is supervision and is it useful?

Other professions which practise something similar in nature to this supervision that counsellors so value, including mental health nursing and clinical psychology, the two other professions involved in this study, have tended to adopt the term 'clinical supervision', apparently to distinguish it from 'managerial supervision', a term more closely associated with the more familiar uses of the term as described above.

However, in the UK, counselling has always resisted using the word 'clinical', largely due to the medical connotations associated with the term. (In this study I have tended to use the terms 'clinical supervision' and 'supervision' almost interchangeably.

Normally, when writing about counselling I have *not* used the word 'clinical' and *have* included it when talking about mental health nursing or clinical psychology. But this is not consistently the case. And this inconsistency is intentional. I want to keep in mind the fact that both terms are used to mean more-or-less the same thing.)

Once the research question had been identified (*what is supervision and is it useful?*) it became clear that literature on supervision derived from a number of different contexts, cultures and professions and in order to understand it, it would be important to include a range of these contexts. So I decided to identify three professions working within the field of mental health in the UK that share a commitment to the practice of clinical supervision and that would enable a broad exploration of the ways in which supervision was practised and, more importantly, the way it was talked

about, its discourse. Details of exactly how I went about this are provided in the methodology chapter.

The exploration that follows is an exploration of the meaning and practice of supervision wherever I could find out about it. The analysis is an analysis of discourse, which therefore includes all the places where supervision is talked about in words. This includes data gathered from my own piece of empirical research as well as a wide variety of literature: academic, grey and professional. It is important to make clear that whilst the literature derives from a number of international contexts, my focus is on the UK and so all the analyses, conclusions and recommendations are drawn with that in mind. Whilst there may be something of interest to others from further afield, it has been my explicit intention to concentrate on implications for mental health practitioners in the UK.

Deciding how to structure this study has not been straightforward, as the exploration was intentionally an iterative process, shifting between the literature and the empirical piece of work, each one informing the other. Interviews were conducted over a three year period and literature was searched and critiqued throughout. I hope this has succeeded in producing a richness of insight, but it has not been a linear process and the structure of this thesis includes much cross-referencing between the various sections; between theory, data, analysis and proposition. I trust that there is sufficient signposting within the sections to provide clarity, but it is intentionally multi-dimensional.

There is a whole chapter on the decision to take a Foucauldian approach to the topic. Essentially, it is his resistance to being defined and identified with any one tradition or perspective that made his approach so attractive. Reading Foucault is like entering into a forest laced with small lanes and pathways, each one leading somewhere

interesting and always somewhere different. That was my experience in undertaking this project, which means that it was at once immensely satisfying – like a journey with an unknown destination - while at the same time immensely frustrating, as I didn't know until the end exactly what the journey had been and whether it had been worthwhile. I now believe it has been worthwhile and I hope the comments in the discussion chapter bring together some important themes and implications for practice. There are many other possible journeys that could have been taken through the material, and could still be taken. But they are for another day ...

Following a brief outline of the background and context in which this study took place, a chapter describing the theoretical position which underpins the entire work is included. The intention is that this will provide an essential basis for understanding the reasons behind the decisions I have taken throughout. This is followed by the more usual methodology and literature review chapters. The literature review comprises three distinct sections: a review of the use of discourse analysis as a methodology in researching into health, a review of the research literature into clinical supervision and finally, a substantial review of the grey and professional literature which provide an essential prerequisite from which to analyse the discourse of supervision in context.

Chapter six outlines the discursive frame onto which the data collected through the empirical research element to the study is analysed. This is followed by the detailed analysis of the empirical data and the concluding chapters: the discussion, conclusion and recommendations.

Chapter two: Background and context

This chapter situates the thesis within the current UK mental health context and provides the necessary background from which an exposition of the theoretical positioning is provided in chapter three.

The practice of (clinical) supervision is recognised as an integral component of continuing professional development and as a professional support mechanism for practitioners working in health and social care. It is a familiar concept, widely valued and supported by professional and organisation policies, at both local and governmental levels (Department of Health (DH 1993), British Psychological Society (BPS 2003), North Essex Mental Health Partnership Trust (NEMHPT 2003), British Association of Counselling and Psychotherapy (BACP 2007 (first published 2002)), Nursing and Midwifery Council (NMC 2008) In some professions, such as counselling and clinical psychology, it is mandatory for the maintenance of professional registration, whilst in others, such as in nursing, its practice is recommended.

In the UK, a number of recent initiatives in mental health practice have the potential to affect the provision and resourcing of supervision. These include

- the increase in multi-professional team working (DH 2009)
- the introduction of the approved mental health practitioner (DH 2008)
- new ways of working with clients/patients, including the personalisation of care (DH 2006d)
- the rise of service user groups involved in the delivery and organisation of care (DH 2009)
- recovery-based approaches to mental health (DH 2009)

In addition, the financial crisis which has impacted the entire UK economy since 2008 is, at the time of writing, causing reductions in public spending and squeezing budgets in every public and service organisation. The implications of this for the resourcing of supervision are unclear.

Each of these developments demands a re-evaluation of the role of the 'professional' in general and of discipline-specific professions in particular. Several of these issues are explored in the literature review of this thesis, and they are relevant to an understanding of the background and context within which this study is situated, not least because they had already started to impact on the work of the participants involved during the data collection period (2005 – 2008). For example, in my final interview with the clinical psychology supervisor (2008), he expressed concern about the future of a specialist psychology service in a context where training in short-term therapeutic interventions was being provided to a range of mental health practitioners as part of the Improved Access to Psychological Therapies initiative. The potential impact of this was seen to be that those patients currently referred to the, much more expensive, clinical psychology service could instead be referred to a, less expensive, mental health worker from a number of other professional backgrounds, and if cost, rather than improved outcomes is the primary driver then this would be a cause for concern. This supervisor expressed caution in the assumption that a twelve week training in cognitive behavioural therapy could equip the practitioner to offer a service comparable to that offered by a clinician with several years of training and experience in offering psychological therapies.

These developments are of particular relevance to the practice of supervision as they raise a number of questions in relation to the provision and resourcing of supervision:

- To what extent should the provision of supervision be safeguarded? Does it offer value for money?

- Does supervision have to be provided by a more experienced practitioner from the same professional background as the supervisee, or would other configurations work just as well?
- As the service user becomes a much more active participant in their own care, is there a future for a practice which talks *about* them but does not directly *include* them?

These are just a few of the questions which may be asked of supervision in the coming months and years.

This study is located within the northern corner of one county in the south east of England. At the time of data collection (2005 – 2008), a local partnership Trust was responsible for the delivery of statutory mental health services to the population. Services included in-patient and out-patient mental health services delivered from two local hospitals and a number of dedicated outreach centres. Community mental health teams were also employed by the Trust, as were clinical psychology services based in the hospitals.

In the same region, there existed an active voluntary sector offering counselling services to specific sectors of the community. Whilst some of these organisations employed paid counsellors, many utilised the services of volunteers, or students building up the required number of counselling hours in order to complete their qualifying courses at the local college which ran a popular accredited counselling course.

Whilst it was never the intention of this thesis directly to address the kinds of questions posed above, it is hoped that through its detailed exploration of the way in which supervision is practised and conceived in this one geographical area, it might

contribute to wider discussions about the value and resourcing of supervision into the future.

Within this national and local context of supervision provision, it is essential that a theoretical approach is adopted which is able to support its complex and multi-paradigmatic nature. The following chapter provides the theoretical underpinnings of a Foucauldian approach that justifies it as being inherently appropriate for researching the practice of supervision in this context.

Chapter three: Theoretical positioning

Introduction

In order to be able robustly to justify the approach taken in this study to the data, to the decisions made in the analysis, to the discussion and to the conclusions drawn, it is first essential to articulate the theoretical underpinning that informs each of those processes. This chapter presents that theoretical foundation by exploring some of the key features of a Foucauldian approach to knowledge and then commenting on the theoretical approach taken towards the concept of discourse. It explores reasons behind opting to take a Foucauldian approach to this study and follows with an exploration of Foucault's contribution to issues of power and knowledge, and to the 'subject' and the 'self'. Taken together, these provide the rationale behind the subsequent methodology and analysis.

Why Foucault?

Foucault's interests are consistent with a constructionist perspective which sees knowledge creation as an active process of collaborative meaning-making in that Foucault explored the way in which knowledge and power are actively produced and negotiated through localised and context-specific mechanisms. His interest was in the rules and practices that produced meaningful statements. He was concerned with both language *and* practices, extending the theoretical structuralist and post-structuralist arguments about representation in language only (after theorists such as Saussure, Althusser, Barthes and Derrida) into a social and historical context. This approach to discourse concerns a whole 'system of representation' and characterises Foucault's archaeological approach to discourse, in which the roots and history of any particular statement are what define and construct the topic itself (Foucault 1972):

Discourse, Foucault argues, constructs the topic. It defines and produces the objects of our knowledge. It governs the way that a topic can be meaningfully talked about and reasoned about. It also influences how ideas are put into practice and used to regulate the conduct of others.

(Hall 2001 p72)

The Order of Things (Foucault 2001 (first published 1970)), provides Foucault's argument for the way in which discourse acts to organise things, making some things possible (because they are sayable) and other things impossible (the unsayable). In this way, it is in discourse that meaning itself is created. Hence, subjects like 'madness', 'punishment', and 'sexuality' (the focus of three of Foucault's major works: *Madness and Civilisation*, first published in 1961 (Foucault 1982), *Discipline and Punish* 1977 and *The History of Sexuality* vols 1-3 1977 – 1984) only exist meaningfully within the discourse about them. Not only does the discourse define what can and cannot be said about a topic, but, by implication also defines the 'truth' about the topic and its 'subjects' (the madman, the criminal, the deviant etc). For Foucault, therefore, nothing has meaning outside of discourse (Foucault 1972).

Epistemes, discursive formations and the emergence of the human sciences

For Foucault, discourse is comprised of *epistemes*, being sets of organising principles that relate things to each other through a system of classification and allocation. For example, Foucault described the Enlightenment, the Classical and the Modern Eras as three distinct epistemes. He argued that these epistemes are so pervasive in nature, being the frameworks within which everything is based, that they become taken for granted. For example, the notion of the autonomous, self-knowing individual who has mastery of his/her own thoughts and actions is so pervasive in our current episteme that it is rarely, if ever questioned. However, as Foucault pointed out, this was not a concept familiar to earlier formations. (The position of the subject is explored on page 21.) For Foucault, any particular episteme is specific to a

particular historical moment and has no inevitable connection or progression from one historical moment to another.

A Foucauldian approach to discourse needs to explore how these epistemes 'speak themselves' through *discursive formations* or 'orders of knowledge'; (Foucault 1972). A constructionist perspective on meaning and representation is consistent with his argument for the way in which discourse is 'historicised'. Danaher, Schirato and Webb highlight three factors that Foucault identified in his analysis of such orders of knowledge: *disciplines*, (within which the objects of knowledge are owned) *commentary* (what the 'experts' say) and *the author* (the 'names' who are consulted and to whom reference is made)(Danaher, Schirato and Webb 2000 p22). In this way, those who claim access to some kind of universal or eternal truth of a discipline (the knowledge), are able to exercise power through which individuals can be regulated and normalised. The way in which this authority and knowledge are regulated within a discipline become apparent through Foucault's identification of the 'human sciences' as the new discipline (Foucault 2003); a science where the individual becomes the site of study, observation and classification. In charting the rise of the new human sciences Foucault concentrated on a small number of specific contexts including psychiatry, the penal system, and sexuality, through which he explored more general principles about power, knowledge, the self and the subject, principles which provide a basis for the discussion of this thesis.

Drawing from the work of Nietzsche, Foucault's genealogical approach to analysis emerged in his later works, including *Discipline and Punish* and *The History Of Sexuality* (Foucault 1977, 1976 – 1984), emphasising not only the historical positioning of topics, but also the relationships between and within them. An understanding of his emphasis on relationships is crucial to a reading of Foucault on

power, and forms the basis of the way in which the discourse is analysed in this thesis.

Power/knowledge

What makes Foucault's approach to the concept of power so interesting in relation to this thesis is the way in which he reconceptualised it into a 'productive network', which permeates every aspect of social life and at all levels:

What makes power hold good, what makes it accepted, is simply the fact that it doesn't only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse
(Foucault 1980 p119).

In this respect, Foucault's interest was in the active 'relations' of power, not in its passive 'being' or existence. Indeed, it is his emphasis on the active nature of each of his concepts ('relations of power', 'domains of knowledge', 'games of truth', 'technologies of the self' etc) that make his approach unique in that each concept is accompanied by a changeable context. Concepts such as power, knowledge and truth are no longer able to remain constant and unchanging as they are produced through the active agency of 'domains', 'relations', 'games' and 'technologies':

There is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time, power relations
(Foucault 1977 p27).

It is this relationship between power and knowledge which, Foucault argued, is used to regulate the conduct of others and the consequent disciplining of practices. If knowledge is historically and socially situated then it produces not 'absolute' truths but 'regimes of truth':

the types of discourse which it accepts and makes function as true, the mechanisms and instances which enable one to distinguish true and false statements, the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true
(Foucault 1980 p131).

Foucault rejected any Marxist, repressive reading of his writing on power, though that critique persists (see Parker 1999 for example). Instead, he saw the operation of relations of power that construct and enable certain knowledge to be known, asserting that “Discourse is the power which is to be seized” (Foucault 1980 p110).

Nonetheless, as Cheek argues in relation to contemporary healthcare:

Paradoxically, such power also constrains what it is possible to know in certain situations.... According to the prevailing discourse in ‘power’, ‘truth’ status is achieved. In contemporary healthcare, the truth status of medical/scientific discursive frames has shaped dominant taken-for-granted understandings of what is appropriate and authoritative practice... At any time in history, certain discourses will operate in such a way as to marginalise or even exclude others. Which discursive frame is afforded presence is a consequence of the effect of power relations.

(Cheek 2004 p1143)

To what extent an awareness of the constraining effect of dominant discourses, such as this ‘hard science’ discourse in health to which Cheek refers, offers an opportunity for other discourses to enter and find space is of particular interest to this thesis: by identifying and critiquing current dominant discursive formations that prevail within the discourse of clinical supervision, can space be made available for other possible discursive formations to be identified?

Foucault was interested in the way in which power relations operate within an institutional apparatus and its ‘technologies’ (Foucault 1980). For Foucault, an Institution comprises both a physical presence (hospital, school etc) and a series of relationships (doctor/nurse; nurse/patient; teacher/pupil; teacher/headteacher etc). Foucault describes the *Art of Governmentality* as the apparatus and systems of the relations of power that define, constrain and order the practices of subjects within the institutions. As Gilbert, Cochrane and Greenwell describe:

Informed by post structuralist thought, governmentality relates to the way contemporary forms of government work through subtle forms of persuasion rather than coercion. Through the use of particular techniques this penetrates into the most minute and distant aspects of individual lives regulating the

autonomous choices of individuals and work to produce self-managing individuals.

(Gilbert, Cochrane and Greenwell 2003 p781).

In relation to the practice of healthcare, Gilbert et al suggest looking at it through this lens of governmentality:

Professional activity provides a conduit for discourses that work to produce particular outcomes for the user of services...Governmentality is concerned with the development of a range of mechanisms through which the population is managed...Social life is first problematised and then acted on in such a way that conduct is managed through the regulation of the autonomous choices of individuals. This process operates through social and moral codes to incite individuals to become self-managing. Governmentality also constructs professional authority with a view to enforcing particular standards of conduct, while individuals who fail to become self-managing are identified, segregated and managed on the basis of risk.

(Gilbert, Cochrane and Greenwell 2003 p782).

Of particular interest to a study of the practice of clinical supervision is the position and function of the individual supervisor and supervisee within the institution and its network of power relations.

The 'subject' and the 'self'

Foucault's famous assertion of the 'death of the subject' (Foucault 2001 (first published 1970)) has been widely misinterpreted as an assertion that the subject has no agency and is entirely constrained by the prevailing discourse, as one definition of the word 'subject' would suggest. Fairclough for example, criticises this 'passive positioning' of the subject (Fairclough 1993). As Hall describes:

subjects may produce particular texts, but they are operating within the limits of the episteme, the discursive formation, the regime of truth, of a particular period and culture... the subject is produced within discourse.

(Hall 2001 p79)

Foucault refers to the concept of *Biopower* as the means by which bodies are regulated through relations of power. He identifies *meticulous rituals* of the everyday practices and mechanisms that constitute the practice of power which are

demonstrated through the socially and historically constituted formation of the *docile body*:

This body is produced within discourse, according to the different discursive formations – the state of knowledge...what counts as 'true'... the specific apparatus and technologies... prevailing at the time.

(Hall 2001 p78)

A constructionist reading of Foucault, however, would suggest that in addition to the subject which is produced by the discourse (the madman, the deviant, the supervisor, the professional etc) and therefore subject to it, the subject is also the reader, observer and interpreter of the discourse and must locate themselves within the historical/social context, by taking up a 'subject position', therefore actively positioning and constituting themselves within prevailing discourses. The 'subject' is therefore at one time both subject *to* and the subject *of* any particular discursive formation. We are not just docile bodies:

worked on by discourses, institutions and power relations. Rather, we are capable of a moral or ethical dimension. Though we may be the effects of power relations, we are not helpless objects formed and moved by power, but individuals constituted as subjects by governmental practices of power and normalisation, and we can choose to respond to, or resist, these practices.

(Danaher, Schirato and Webb 2000 p128).

In this way, as Danaher et al go on to argue, while institutions may work to produce docile bodies, they are just as likely to produce rebels.

Foucault's description of the *technologies of the self*, developed in his final works (Foucault 1976 – 1984) describes the various practices and techniques that individuals choose to subject themselves to in order to regulate their thoughts, their bodies and their behaviour. Foucault demonstrated how, in earlier epistemes, any regulation of the body was an external process instigated by others. With the arrival of Bentham's Panopticon, a physical representation of an invisible but ever-present 'eye', new discourses emerge which value the internalisation of these self-regulatory practices. As Parker asserts in relation to the therapeutic relationship,

a therapeutic discourse is a function of this apparatus of self-regulation and confession, and the text can be interpreted as an instance of that apparatus.
(Parker 1999 p586).

Summary of Foucault's theoretical contribution relevant to this study

As Armstrong notes, there are many different Foucaults and many different readings of Foucault (Parker 1995; Armstrong 1997 p15). A social constructionist reading of Foucault indicates that knowledge is historically and socially constructed and constrained by the regimes of truth that constitute the particular objects of knowledge in any given field. These objects are owned by the identified disciplines, commentary and authors. Between them, these three elements represent the truth, or knowledge, held within that field and so, by implication, define what may be included and excluded, either at the local (discipline-based) or general (cultural-based) level. In order to become a member of the discipline, it is imperative to maintain and not resist this knowledge of the truth. Any individual with a relationship to the field is subject to these games of truth and relations of power. Nevertheless, by the very act of being recognised as a subject in the field, s/he also has the opportunity to be an active agent, even a site of resistance to the practices and formations within that field. Recent formations of the 'self' have generated a culture of self-examination and self-regulation.

Discourse

[Discourse has become] common currency in a variety of disciplines... so much so that it is frequently left undefined, as if its usage were simply common knowledge ... It has perhaps the widest range of possible significations of any term in literary and cultural theory, and yet it is often the term within theoretical texts which is least defined.

(Mills 1997 p1).

In a purely linguistic sense, the term 'discourse' conveys the meaning of passages of connected writing or speech. A slightly broader definition might be that it relates to 'language in use', the way humans make meaning through language, as Parker suggests: "a good working definition of a discourse should be that it is a system of

statements which constructs an object” (Parker 1992 p5), though as Cheek recognises, “the definition of discourse in use at any particular time reflects its theoretical underpinning” (Cheek 2004 p1142).

For the purposes of this thesis, a definition which is consistent with a Foucauldian approach is needed. It therefore needs to be consistent with a recognition that:

language is always a socially and historically situated mode of action, in a dialectical relationship with other facets of the ‘social’ ... it is socially shaped, but it is also socially shaping or constitutive.

(Fairclough 1993 p134).

Of particular interest in this thesis is the relation between *text* and *practice*:

each discursive event has three dimensions or facets: it is a spoken or written language text, it is an instance of discourse practice involving the production and interpretation of text and it is a piece of social practice.

(Fairclough 1993 p136).

Cheek provides an articulation of this theoretical underpinning in her description of the relationship between text and context:

The ways in which a text represents aspects of reality – the ‘conventionalized practices’ (from Fairclough 1993 p194)... or the assumptions that a text makes in presuming that it will be understood are of as much interest as what the text actually describes. Furthermore, texts not only represent and reflect a certain version of reality; they also play a part in the very construction and maintenance of that reality itself. There is a dynamic relationship between the text and the context within which the text is produced. Texts are both constitutive of and, in turn, constructed by their context... All of this is to challenge the notion of ‘natural’ or authentic images of reality.

(Cheek 2004 p1144-5)

As indicated above, for Foucault, a discourse consists of those assumptions that can be so taken-for-granted that they can be invisible, so any definition of discourse needs to express something of the possibility of what can, and what can’t, be said or thought about aspects of reality within any particular context. Cheek provides a definition which most closely brings together these aspects and is the one used as the benchmark definition for this thesis:

[discourse] consists of a set of common assumptions that sometimes, indeed often, may be so taken for granted as to be invisible or assumed. ...[They] are scaffolds of discursive frameworks, which order reality in a certain way. They both enable and constrain the production of knowledge, in that they allow for certain ways of thinking about reality while excluding others. In this way, they determine who can speak, when, and with what authority; and, conversely, who cannot.

(Cheek 2004 p1142)

These theoretical assumptions around the nature of discourse and knowledge underpin the way in which the entire thesis is predicated and the following chapters should be read with that in mind. The next chapter provides a detailed account of the specific methodology used to apply these theoretical underpinning to the delivery of an empirical study.

Chapter four: Methodology

Introduction

One of the major criticisms directed at Foucault's approach is his apparent lack of application (Fairclough 1992). In fact, Foucault persistently avoided providing *any* systematic method, and resisted any attempt to be defined by any one particular approach, or even any one particular discipline:

Do not ask who I am and do not ask me to remain the same: leave it to our bureaucrats and our police to see that our papers are in order
(Foucault 1972 p19)

This thesis seeks to address this by accepting that Foucault's method offers an approach rather than a process. For this reason, the methodology which follows has been constructed in a way which is consistent with the theoretical approach outlined in the previous chapter, whilst at the same time detailing a specific process which is transparent and open to interrogation. In order to be consistent with Foucault's approach, it was crucial to identify specific *discursive formations* (p17) around the topic of clinical supervision and attempt to locate them within their historical context. Once this has been done, it was then possible to look for ways in which the research participants seemed to draw from these formations in what they said, and did not say about the practice of supervision. The literature search, therefore, performs a dual function: the more conventional purpose of establishing the nature and content of the body of research into the topic but, critically, also of comprising a substantial part of the data itself, providing the material/content from which the discursive formations are drawn. Consequently, the balance between literature and empirical data is unconventionally weighted towards the literature. This methodology, therefore, consists of five numbered sections:

1. A description of the methods underpinning the construction of the *discursive frame*
2. The conduct of the empirical aspect of research (on page 28)
3. The application of the discursive frame to the data (on page 35)
4. ethical concerns of the study (p 37)
5. Comments about actions taken to ensure its rigorous conduct (p 40).

1. The construction of a discursive frame

In line with Foucault's archaeological approach to discourse, as outlined on page 16, the roots and history of particular instances of discourse need to be traced. In order to achieve this, an early and extensive literature review was undertaken. This review sought to identify the history of prevalent discourses of clinical supervision. The review included both academic and professional literature, and involved several iterations as one piece of literature identified further possibilities. The literature identified through this comprehensive review provided the content knowledge around the discourses and enabled the identification of discursive formulations within supervision and, in turn, enabled the construction of a discursive frame.

Identifying and articulating this discursive frame could never have been an objective process, nor was it intended to be. Drawing from interpretive research paradigms (Holloway and Carroll 1996) my interest as a researcher is acknowledged and used as part of the data. My reading of the literature is one reading among many and is offered in that light. Further detail about the ethical concerns with this approach is provided in the section on reflexive ethical considerations on page 38. This frame provides the basis from which the subsequent analysis of the empirical data can relate. Further detail about the conduct of the literature review is provided in chapter five and the discursive frame which derived from it is presented in chapter six.

2. The conduct of the empirical research

The empirical aspect of this thesis comprises an analysis of three case studies of actual supervisory practice. This section of the methodology describes the nature of the case studies as well as the method of data collection and a note on the conduct of interviews.

An exploratory multiple case study

Good case study is patient, reflective, willing to see another view

(Stake 1995 p12)

A case study approach was chosen as it is an approach which “allows investigators to retain the holistic and meaningful characteristics of real-life events” (Yin 2003 p2). It was this attempt to gain a *holistic* view which made the approach relevant for this study, as such an approach enables research participants to be situated *within their context* by identifying and articulating the nature of the context, local, national and professional within which all their practice is located. In this way the participant discourse is seen to be both influenced by and influencing the wider professional discourse and current *discursive formations* (p17). By taking a case study approach each of these influences is respected and incorporated and as such is consistent with the espoused Foucauldian approach.

This study focuses on three case studies, and as such can be likened to the *multiple case study design* as described by Yin (Yin 2003). However, whilst Yin suggests that the purpose of a multiple case study approach as opposed to a single case study is to validate theory through replication, in this study, three case studies have been identified in order to increase the potential diversity of the text derived from them. Whilst it was the intention to explore commonalities in terms of ways in which the

participants engaged with the dominant discourses, this was not for the purpose of replication for validation of any theory. Instead, the intention was to explore *a range* of practices and contexts which draw from the dominant discourses. Yin does, however, helpfully define three kinds of case studies: *explanatory*, *descriptive* and *exploratory*, and it is this final type which is adopted by this study.

Initially, all professions within health and social care which practise a form of clinical supervision were scoped. These included social work and medicine. However, once the sheer quantity of the literature within each of these professions became apparent, it was clear that it would be too large to be feasible. It was decided to limit the study to three professional groups and the three chosen (counselling, clinical psychology and mental health nursing) were identified largely for pragmatic reasons and ease of access for research purposes. This is a potential limitation of the study but they do at least provide the opportunity for at least some diversity of practice to be identified across the three case studies. Further diversity was sought by gathering data from each case study at three separate points across three years. The intention was to provide an opportunity for any changes of practice over time to be observed. In this way, the potential was there for the data to provide insights across professions at one particular point in time as well as within professions across a longer period of time.

Each case study can be conceptualised as a series of concentric circles, where the discourse of the actual supervision session itself forms the hub, surrounded by the local discourse, including how the practitioners themselves talked about their practice (through the interviews), and other local discourse such as Trust policies and guidelines. The outer circle comprises discourse at a national level, including academic and professional literature, government and professional body policies and guidelines (see figure 1). In this way the *micro*, *meso* and *macro* levels of discourse each have the opportunity to be identified and explored (Fairclough 1992).

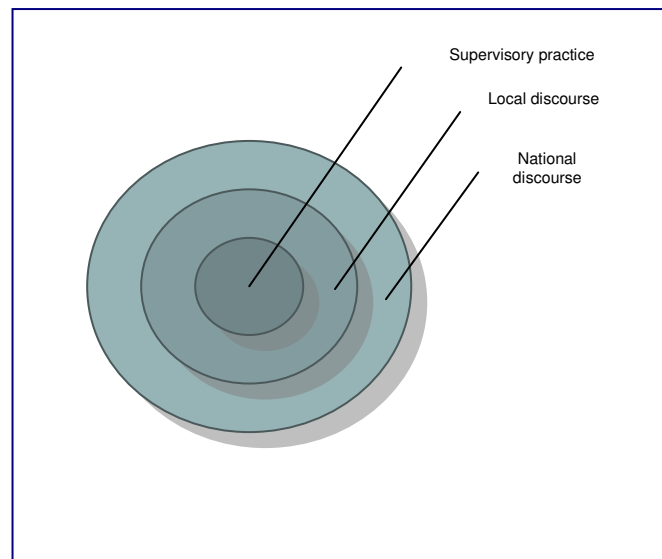


Figure 1 Individual Case Study

Stake refers to the use of more than one case study as a *collective* case study (Stake 1995). This is a helpful way of seeing the multiple case studies in this project as being interconnecting, suggesting that the whole may be greater than the sum of the parts. So, instead of visualising the three case studies as three discrete sets of concentric circles, it is more helpful to see them as interconnected. This allows for the recognition that whilst the individual supervisory practices are distinct, some of the local and national discourses may be common between the cases. (See figure 2)

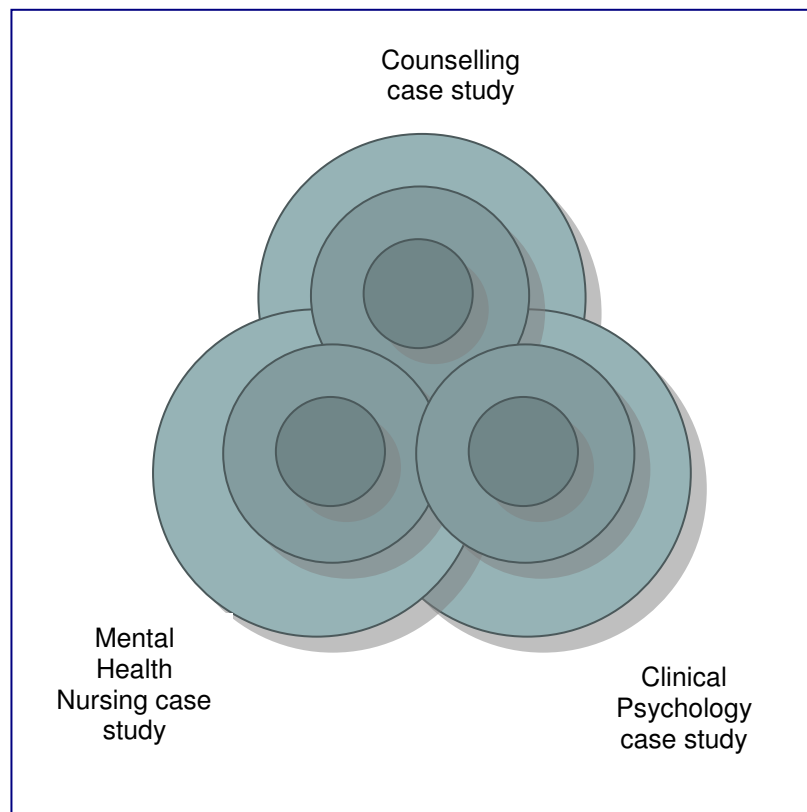


Figure 2 Case Study Connections

Stake also differentiates between the *intrinsic* and the *instrumental* case study, the latter being one where a single case study is used as a means to understand more than just that one case. It is a means by which understanding of something else can be derived. In the sense that each of the three case studies in this study serves to illuminate and illustrate examples that may occur elsewhere (what Stake describes as *petites generalisations*), then these case studies are certainly instrumental. However, every attempt has been made to resist the temptation to assume that a case study of supervision in mental health nursing, for example, is in any way representative of the practice of supervision in mental health nursing in general; to do so would not only be a different project but would require a very different methodology. As Stake concisely states, “case study research is not sampling research” (Stake 1995 p4). For the same reason, I did not seek to identify a ‘typical’

example of clinical supervision in each of the three identified professions; Stake again: “good instrumental case study does not depend on being able to defend typicality of [a case].” (Stake 1995 p4). Guba and Lincoln refer to the possibility of case study research facilitating the transfer of findings from one setting to another on the basis of *fit* (Guba and Lincoln 1989) which is a helpful way of recognising the value of some comparison. However, as every context is unique, the onus is on the reader to interpret the level of ‘fitness’ of these cases to their own contexts.

Data collection

Data collected from each case study comprised:

1. at the *micro* level: transcripts of three actual supervisory sessions between a supervisor and supervisee, recorded, without a researcher present, once a year over three years (2006/7, 2007/8, 2008/9)
2. at the *meso* level: transcripts of individual interviews with each participant following as soon as practicably possible after each recorded supervisory session. These were semi-structured interviews lasting between 45 minutes and an hour. During the interviews, participants were asked to name any literature or documentation which may have an impact on their supervision practice. I suggested that they may like to consider whether they were in receipt of any training with its materials, or any local or national policies or any of their own reading which may have influenced their current practice. Any recommendations made in this way were followed up.
3. at the *macro* level: accompanying professional and policy literature related to the practice of supervision in the identified professions, identified through a literature search as described in detail in the literature review on page 42.

Recruitment

Six practitioners from three professions that practise some form of clinical supervision and who work directly with clients/patients/service users in the field of mental health were recruited. As indicated above, these professions were finally identified as mental health nursing, clinical psychology and counselling. A supervisor and one of their current supervisees were recruited as a partnership. The participants from mental health nursing and clinical psychology were recruited through a NHS mental health Trust and the counselling participants through a University. The participant invitation letter, information sheet and consent form can be found in the appendices on page 259. Initial recruitment activity sought to recruit newly qualified practitioners in order to provide the opportunity to explore any changes in discourse over time as the practitioners became increasingly experienced. For this reason, the interviews were spread out over a three year period allowing for the practitioners to gain experience. However, whilst the first round of interviews was conducted with partnerships in which the supervisee was newly qualified, none of the case studies provided a great deal of opportunity for a longitudinal analysis. In the event, neither the nursing nor the counselling partnerships continued throughout the three year period, necessitating the recruitment of new participants for the final year (though the counselling supervisor remained the same). In addition, contact was lost with the clinical psychology partnership after the second year's interviews despite repeated attempts to re-establish contact. It was decided that it would be inappropriate and unethical to continue to pursue contact. For this reason, out of a planned 27 individual data transcripts (9 supervisory sessions, plus 18 individual interviews), the final total was 24 (8 sessions and 16 interviews) and the total number of participants involved at some point in the study was nine (four supervisors and five supervisees). Nonetheless, there was sufficient quantity of data to enable the study to achieve its

overall aim of exploring the diverse ways in which practitioners from three distinct but complementary professions engage in and talk about supervision and ways in which they draw from the identified dominant discourses.

The various elements to the data collection described above can be summarised thus:

	Year 1	Year 2	Year 3
Data from Clinical Psychology dyad	Interviews 1 & 2	Interviews 3 & 4	Did not occur
Academic, professional and grey clinical psychology literature	-----→		
Data from Mental Health Nursing dyad	Interviews 1 & 2	Interviews 3 & 4	Interviews 5 & 6
Academic, professional and grey Mental Health Nursing literature	-----→		
Data from Counselling dyad	Interviews 1 & 2	Interviews 3 & 4	Interviews 5 & 6
Academic, professional and grey Counselling literature	-----→		
Generic academic, professional and grey literature on supervision	-----→		

Table 1 Summary of data collection elements

The transcripts of all interviews and live supervision sessions have been collated into one document in which line numbering starts with the first counselling supervision session and runs through to the final interview. In the analysis that follows, I have indicated throughout which person is speaking (e.g. counselling supervisor, clinical psychology supervisee) and, where appropriate, from which interview/session the quote derives. For reference, a list is provided of the line numbering associated with each interview/session in appendix five. All identifying details have been removed from the transcripts

A note on interviews

As an experienced counsellor, practised in undertaking interpersonal interviews, and also a relatively inexperienced researcher, I was keenly aware of the need to familiarise myself with the important differences between a therapeutic and a research interview and to ensure that I was acting with integrity and in an ethical manner towards my participants. (See on page 37 for an analysis of the ethical considerations of this study.)

I have argued elsewhere (Bulpitt and Martin 2010) that the published literature on the differences between the two types of interview is unsatisfactory, focussing as it does either on the *therapeutic potential* of the research interview (Colbourne and Sque 2005 for example) or the danger for the researcher not having the relevant skills to *manage* a therapeutic interview (Kvale 1996). I remain unconvinced by either of these arguments. However, for the purposes of this study, having recognised the potential for some conflation of types of interview and the need to remain clear about the specific purposes of these research interviews, I produced a protocol for the kinds of discussion topics I was hoping to include in the semi-structured interviews that I undertook (see Appendix one on page 258). Further comment on the ethical implications of this is found on p37.

3. The application of the discursive frame to the data

Having identified the dominant discourses through the extensive literature review and collected the empirical data as described above, the analysis could then begin. Each transcript was scrutinised in order to identify ways in which participants both drew from, and resisted these identified discourses. As indicated at the start of this methodology chapter, Foucault characteristically avoided providing any kind of systematic method for doing this, so this study draws from two sources which help to

operationalise this approach in a way which is practicable while remaining consistent with the underpinning assumptions. (Kendall and Wickham 1999; Cheek 2004).

Finding the rules and establishing the system

Cheek presents a number of questions that could be asked of the data from a

Foucauldian perspective:

- *What rules permit certain statements to be made?*
- *What rules order these statements?*
- *What rules permit us to identify some statements as true and some false?*
- *What rules allow for the construction of a map, model or classificatory system?*

(Cheek 2004 p1142)

Furthermore, Kendall and Wickham operationalise Foucault's archaeological method by suggesting that research should attempt to chart the relation between the 'sayable' and the 'visible', the "dynamic, mutually conditioning relationship between the words and the things" (Kendall and Wickham 1999 p27). In other words, analysis should explore what kind of relationship exists between what is observed in the physical environments represented by the respondents in the research and what is 'said' through the related documentation, policies, theories and such like? Kendall and Wickham go on to suggest questions that could be asked in interrogating the data. Those that were the particular focus for this analysis were:

- *What rules can be formulated for the repeatability of statements?*
- *What procedures are used to deploy some statements rather than others?*
- *What positions are established between the various subjects?*
- *From Foucault's genealogical approach to a history of the present: How has power been constructed? (What "various bits and pieces" needed to be in place to allow something else to be possible?)*

(adapted from Kendall and Wickham 1999 pp34 - 37)

In analysing the entire data set, these two sets of questions were used as a framework to guide my thinking and steer my observations of what was happening in the text. However, just as Foucault resisted being tied to a prescriptive process, I too

was committed to the need not to become formulaic in my approach to the data as this, in itself, would run contrary to the meaning-making and constructionist paradigm within which I was positioned. So these questions were used as a guideline, not a straitjacket.

The aim of analysing the data in this way was to bring into awareness those taken-for-granted assumptions and every-day practices that maintain current relations of power and knowledge. Identifying the relations of power is essential to a Foucauldian approach to discourse. Kendall and Wickham suggest that it is the *relations* of power that serve to make the connections between the visible and the sayable, power being the productive strategy which maintains the relation between them (Kendall and Wickham 1999) and an analysis of this aspect forms the basis of the discussion chapter.

The intention is that such a problematisation of the dominant discourses around clinical supervision will enable the possibility of new formulations to emerge and possible new ways of working to be considered.

4. Ethics

This section identifies both the practical steps taken to ensure the conduct of an ethical study (gaining approval and maintaining confidentiality) as well as a reflexive commentary on broader ethical considerations.

Gaining approval

Formal ethical approval was sought and gained from the Central Office for Research Ethics Committees (COREC) in 2005 for the conduct of this study. Further approval was also gained from the NHS Trust's Research and Development Committee. As I was not an employee of the Trust, criminal record checks had to be confirmed and an

honorary contract drawn up. This was all completed in advance of any contact with Trust employees.

As the participants from the counselling profession were not employed by the Trust, appropriate ethical conduct towards these participants was discussed with my supervisor. It was agreed that exactly the same protocols should be applied to them as to those participants employed by the Trust (including the participant information sheets, consent forms, contact arrangements, management of data etc see Appendix two – four on page 259).

Maintaining confidentiality

Interviews were transcribed by a commercial transcription company. Their confidentiality policy was scrutinised and it was confirmed that all data files received by the company were permanently deleted once the transcripts were returned to the customer. They used an online system of data transfer, so no paper copies were created.

Data (transcripts and digital recordings) were stored on a memory stick in a secure location. One back-up copy of all data was kept on an external hard drive, also kept in a secure location.

All transcripts were anonymised immediately, including all names, locations, and other identifiable details.

Reflexive ethical considerations

Throughout the course of undertaking the research I was cognisant of a number of ethical issues which I sought to address through a reflexive approach, which included regular reflections in a research diary and conversations with my supervisor. The

application of reflexive methodologies has been proposed as a means by which the researcher's process is made transparent and used as part of the data (Alvesson and Kärreman 2000; Alvesson and Skoldberg 2000; Freshwater and Rolfe 2001; Carolan 2003; Etherington 2004; Bulpitt and Martin 2010). In a qualitative study such as this one, there is an ethical obligation for a qualitative researcher to make this data available, providing as it does an important means by which the validity of the findings can be justified and any potential transferability can be genuinely assessed by a reader.

Undertaking this reflexive approach towards my initial interviews raised a number of ethical concerns, recently published (Bulpitt and Martin 2010), concerning the potential for an 'expert' interviewer to manipulate the interviewee into exposing more personal and revealing information than they may otherwise have been willing to give. As an experienced counsellor myself, I became quickly aware that I had at my disposal a number of interventions that could invoke a more therapeutic tone to the interview, and so potentially invite intimate and emotive responses from the interviewees. There could be a temptation to congratulate myself for the way in which I managed to gather such rich and interesting data to inform my study, but a reflexive approach to this experience alerted me to the ethical dilemma that this raised: the interviewee never agreed to embark on a therapeutic session with a counsellor. Indeed, they did not know that I was a counsellor. They agreed to 'help' me conduct a genuine research project. They did not agree to be 'helped' by me at some quasi-therapeutic level. An ethical approach obliged me to be alert to this potential and, whilst I remained eager to gather rich data, it was imperative that my interventions were confined within the boundaries of the consent given.

In addition to this awareness, I also became quickly aware of the difference in professional knowledge and experience between me and my interviewees. As a counsellor myself, my own professional experience carries with it potential risks that the discrepancy in my knowledge, skills and understanding between the respondents from the counselling profession and those from the nursing and psychology professions could seriously skew the nature and quality of data I was able to collect through the interviews. There existed the very real risk that my prior assumptions may cause me to miss opportunities to explore more detailed analysis and explanations of meaning within the counselling context. I took the decision not to tell my participants that I was a counsellor myself as I wanted to avoid the possibility that they would make assumptions about me and my role in the research. On subsequent reflection, I wondered whether this caused the interviews to be less transparent and therefore less consistent with my espoused approach to the collecting and analysing of the data, than they otherwise might have been.

5. A rigorous study

Bernard and Goodyear suggest that case study research sits comfortably within a first stage of supervision research, the *descriptive* stage, where the second and third stages are testing hypotheses, and building theory respectively (Bernard and Goodyear 1998). Whilst I accept that my study is largely descriptive, I do *not* accept that it serves simply as a precursor to testing hypotheses and building theory.

Bernard and Goodyear's statement suggests that they were drawing from a largely positivistic research paradigm, one of which much good supervision research has fallen foul and one which I would strongly resist. There is much good research into clinical supervision which has been rejected by the few systematic reviews that have been undertaken to date (Ellis, Ladany and Krenzel 1996; Wheeler and Richards 2007) on the basis that it does not meet the inclusion criteria, criteria that are based on largely quantitative, and positivist paradigms. This issue around the status of

diverse research paradigms is explored in the discussion chapter and in depth in the literature review on page 47 as it became clear during this study that this is a critical issue in the profile of supervision research. This thesis seeks to present a rigorous and unapologetic account of a piece of qualitative research which can, as a single piece of work, stand up to scrutiny on methodological grounds, inform the debate about the practice usefulness and practice of supervision and influence actual practice. It is descriptive, but it is not incomplete without Bernard and Goodyear's second and third stages.

Many of the elements designed to provide the necessary rigour to this study have been identified in sections above, but they include a transparent and reflexive account of the rationale, protocols and procedures undertaken in order that an audit trail of decision-making can be followed and scrutinised by others. (Ladany 2004; Koch 2006 (first published 1994)):

Researchers need to consciously reflect on the dual roles and declare, rather than deny, their complex layers of identity.

(Leslie and McAllister 2002 p703)

In addition, this thesis aims to provide an honest presentation of findings, including their conditionality and provisional nature and the need to be clear that any conclusions are considered and transparent, a 'considered response' (Barbour 2003 p1019).

Having described in detail the way in which I operationalised a study consistent with a Foucauldian approach, the next chapter provides a comprehensive literature review which serves as the basis from which the subsequent discursive frame is derived.

Chapter five: Literature review

Introduction

As indicated in the methodology chapter on page 27, the intention of this review is to provide an overview of the research undertaken in order ultimately to identify the dominant discourses around supervision. Discourses identified in this way informed the construction of the discursive frame (chapter six) with which the empirical data were analysed.

The review begins with a description of the search methodology, followed by a comment about the context and rigour of the review. Two conventional literature review sections follow, reviewing research undertaken into clinical supervision to date as well as the use of discourse analysis as a methodology for researching into health. The final section of the chapter is a comprehensive review of the professional literature as a means to trace the origins and history of the dominant discourses of supervision (on page 92).

Search methodology

The review of literature of research undertaken into clinical supervision together with a review of literature into the use of discourse analysis as a methodology for researching health provide the context within which this thesis is situated and was collected according to the process described below.

Between 2005 and 2007 a comprehensive search of relevant databases was conducted. These databases were accessed through the Albert Sloman Library at the University of Essex and included those recommended by the library to be relevant to studies in health. These include psychinfo, cinahl, eric and others. It is recognised that a number of these databases have since been renamed and/or

reconfigured. Search terms used included derivations of 'supervision', 'clinical supervision' and 'mental health nursing', 'counselling', and 'clinical psychology'. Related terms were also searched, including derivatives of 'mentorship' and 'preceptorship'. Initially, these terms were searched solely within the title of publications, in order to establish the quantity of publications in the field. Subsequent searches included these terms within abstracts also.

It is recognised that some relevant literature was not discovered, including some deriving from related health professions. This was problematic as any search that includes the term 'health' inevitably identified a vast number of publications. In addition, as indicated in the Introduction on page 7, the term 'supervision' carries other meanings, including workforce and academic supervision, so searches had to be refined in order to eliminate these.

Once a first trawl of literature had been identified, it was then possible to scan references within these publications and follow up on additional relevant publications. Once this process ceased to reveal substantial numbers of new publications it was assumed that an initial saturation point had been reached. In subsequent years (2007 – 2010), an ongoing strategy of scanning the contents list of relevant journals was routinely undertaken in order to identify relevant new publications. Journals that were routinely scrutinised in this way include

- Journal of Nursing Management
- Journal of Advanced Nursing
- Journal of Psychiatric and Mental Health Nursing
- British Journal of Guidance and Counselling
- International Journal of Nursing Practice
- British Journal of Clinical Psychology

For the final section of this literature review, the review of the professional literature, a comprehensive search was undertaken to identify and locate documentation which informs the wider professional context of the three case studies. One approach to assist in the identification of relevant documentation, including current policies and approaches to clinical supervision, was to hold telephone conversations with education leads of professional bodies of each of the three professions. Notes were taken of these conversations and recommendations followed up. An informal interview was also held with two senior members of staff from the Trust in which the research was undertaken. One of these members of staff was the person responsible for the development and implementation of the Trust's supervision policy.

Finally, a search for clinical supervision documentation on the internet was undertaken. This included the websites of professional, statutory and regulatory bodies of each of the three professions as well as the Department of Health and National Health Service. References to further links and literature were also followed up, as were references to policy documentation within the wider academic literature. The documentation collected in this way comprised academic literature as well as governmental, professional and local literature, policies and procedures.

Context and rigour

As suggested on page 40, problems exist in that there are conflicting assumptions around approaches and methodologies appropriate to the researching of clinical supervision. It is for this reason that, before considering the research literature, some words are included regarding the context and rigour of research into supervision in health and the consequent problems with most, if not all, published reviews on the literature around supervision.

Context

The impact of professional, cultural and contextual differences between studies reported in the literature has not been adequately articulated. Internationally, there are a number of active researchers consistently publishing in the area of clinical supervision, each with its own particular focus. In the broadest of terms these include writers from Scandinavia, Australia, the United States and the UK:

Scandinavia

A large body of literature derives from a Scandinavian context including a number of authors who often publish collaboratively from Finland. These authors' interests focus around the ways in which clinical supervision relates to issues of leadership and management as well as conceptions of clinical supervision itself (Hyrkas, Koivula and Paunonen 1999; Hyrkas, Appelqvist-Schmidlecher and Paunonen-Ilmonen 2002; Hyrkas and Appelqvist-Schmidlecher 2003; Hyrkas 2005; Hyrkäs 2006; Hyrkas, Appelqvist-Schmidlecher and Haataja 2006; Sirola-Karvinen and Hykas 2006) and another group, also often publishing together, from Norway and Sweden (Severinsson 1996; Severinsson and Hallberg 1996; Severinsson and Borgenhammar 1997; Berg and Hallberg 1999; 2000; Arvidsson, Lofgren and Fridlund 2001; Berggren and Severinsson 2003; Arvidsson and Fridlund 2005; Berggren, Barbosa da Silva and Severinsson 2005; Bégat and Severinsson 2006; Berggren and Severinsson 2006; Berg and Kisthinos 2007).

Australia

Much smaller numbers of researchers from Australia publish work on some of the difficulties with implementation of clinical supervision (Walsh, Nicholson, Kedugh, Pridham, Kramer and Jeffrey 2003; Hancox, Lynch, Happell and Biondon 2004; Cleary and Freeman 2005; White and Winstanley 2006).

United States

Writers from the United States, whose approach to research tends to favour a positivistic paradigm, focus almost exclusively on the supervision of trainees, given that very little post-qualifying supervision takes place in the US (Holloway and Neufeldt 1995; Holloway and Poulin 1995; Holloway and Carroll 1996).

United Kingdom

A number of researchers from the UK have tended to be more open to a post-modern turn in their studies and their interests include the role of reflective practice in clinical supervision as well as the recurring problems with implementation and development. Authors in the UK have also produced some evaluative studies and proposed developments on alternative, less hierarchical formats (Butterworth, Bishop and Carson 1996; Butterworth, Carson and White 1997; Butterworth and Faugier 1998; Jones 1998; 2000; Milne and James 2000; Stevenson and Jackson 2000; Gilbert 2001; Johns 2001; Davy 2002; Grant 2003; Wheeler 2003; Stevenson 2005; Townend 2005; Jones 2006; Stevenson and Cutcliffe 2006; Grant and Townend 2007; Milne 2007; Wheeler and Richards 2007; Butterworth 2008; Townend 2008).

In addition, each of these groups is located almost exclusively within the nursing profession, with the exception of some of the UK literature around reflective practice which include some of the allied health professions in the discussions. There are very few individual researchers who routinely publish on the subject from other mental health professions though there are examples in counselling e.g. Wheeler and psychology e.g. Milne, both of whom have published reviews of the literature on clinical supervision for their respective professions (Milne and James 2000; Wheeler 2003; Wheeler and Richards 2007).

Given the relatively small literature on clinical supervision overall, there is a regrettable tendency for researchers to refer liberally, and too often indiscriminately, from any or all of these groups, cultures and disciplines, often with no reference to the potential impact the contextual differences may have on any individual study.

This is a critical issue and is taken up in the conclusion on page 227.

Rigour

The quality of research into clinical supervision has been the subject of some debate, largely in respect of a perceived lack of rigour in the qualitative approaches used (Ellis, Ladany and Krenzel 1996). In addition to this review undertaken by Ellis and colleagues, an overview of clinical supervision in nursing was undertaken by Hyrkas Koivula and Paunonen which concluded that research into supervisory effectiveness is still in its infancy (Hyrkas, Koivula and Paunonen 1999). The problem with this review, however, is that the authors chose to use the evaluation criteria identified by Ellis, Ladany and Krenzel, whose approach is strongly influenced by what Holloway and Carroll have described as a post-positivistic paradigm (Ellis, Ladany and Krenzel 1996); the problem with this is that the vast majority of the studies under review by both Ellis et al. and by Hyrkäs and colleagues site themselves within an increasingly *interpretive* paradigm (Holloway and Carroll 1996). This imposition of evaluative criteria from one paradigm (post-positivistic) onto research carried out in another paradigm (interpretive) seriously undermines the rigour of the conclusions of both reviews, rather like evaluating oranges using the characteristics of an apple. It is unsurprising that Hyrkäs et al conclude: “our examination has exposed many problems and factors reducing the reliability of the results...” (Hyrkas, Koivula and Paunonen 1999 p183), arguing as they do for a clarification of concepts, an increase in scientific rigour of research and the development of theory. “To do this,

supervision studies should have large samples and use reliable instruments” (Hyrkas, Koivula and Paunonen 1999 p184). Whilst I recognise there is a valuable place for such studies, I strongly contest that *only* these kinds of studies produce reliable results. Holloway and Carroll, in their own review of supervision research, refer to this as “the tension between field relevancy and methodological rigor” (Holloway and Carroll 1996 p51). Their response to the earlier review by Ellis and colleagues stresses the need to contextualise supervision research and address the distinctives of the British approach. Whilst I support these aims, the issue over what counts as evidence remains largely unresolved. Meanwhile the positivistic paradigm continues to assert its historical dominance over newer methodologies.

As will be demonstrated in the discursive frame chapter (chapter six), therapeutic approaches have informed much of the practice of supervision, due to the influence of counselling and psychotherapy on the origins of supervision. Of all the therapeutic approaches within which clinical supervision has been practised, it is the cognitive behavioural approach (CBT) that has gained the most credibility through evidence-based research in recent years (Milne and James 2000; Sloan, White and Coit 2000; Waskett and Shone 2006; Townend 2008). This may well be attributable to this same hegemony of the post-positivist research paradigm as suggested in the paragraph above, leading to the devaluing of those more pluralistic research methodologies often utilised by other therapeutic traditions such as the psychodynamic or humanistic. See, for example the recent *Improving Access to Psychological Therapies* (IAPT) programme, a joint Department of Health and Care Services Improvement Partnership (CSIP) pilot project, which was launched by the then Health Secretary, Patricia Hewitt, in 2006 which recommends CBT as the *only* approach to receive funding under this initiative.

<http://www.mhchoice.csip.org.uk/psychological-therapies.html> (accessed 25.08.08).

An example of the tautological consequences of this lack of clarity can be identified in the similar foregrounding of the cognitive behavioural approach (CBT) as being the only approach supported by evidence of effectiveness within the practice of clinical supervision. It is self-evidently true that an approach, such as CBT, which itself derives from, and is structured around, quantitative, measurable forms of analysis is going to emerge as being more effective than similar analyses being applied to approaches which are not so easily measured, such as the person-centred or psychodynamic approaches. If review authors' rejection of such studies is due only to the definitions of their own inclusion criteria, then this predetermines the outcome in terms of recommendations of their effectiveness. Despite longstanding and robust theoretical arguments for research methodologies that more congruently reflect the holistic, personalised and intimate nature of nursing practice (Leininger 1985; Traynor 1996), including more recent feminist research (Hagell 1989), these arguments do not appear to have translated into a wide scale academic acceptance of such methodologies. In the current climate in UK healthcare practice where so-called *evidence-based practice* is seen as the gold standard, then a diversity of practice within clinical supervision is unlikely unless this status quo is robustly challenged.

Taken together, these two concerns in respect of *context* and *rigour* risk jeopardising the credibility of much supervision research. It is for this reason that this study makes a genuine and serious attempt consistently to identify and articulate *contextual* factors and to provide a transparent account of the research process, in order that it can go some way to counter these risks. The first step towards achieving this is to review the literature on the use of discourse analysis as an appropriate methodology for researching health in general, and clinical supervision in particular.

Review section one: discourse analysis as a methodology for research in health

Foucault's approach to discourse and its analysis is just one approach among many. The section that follows reviews the ways in which discourse analysis has been used as a methodology within health research. Whilst providing a justification for the approach as an appropriate research method in health in general, it will also help to articulate why Foucault's approach in particular is consistent with achieving the aims of this thesis.

Williams and Irving highlight the need to be aware of the variety of discourses going on, the *universes of discourse* and their potentially idiosyncratic nature (Williams and Irving 2002). Whilst their comments are addressed specifically to those involved in counselling and psychotherapy, their observation is relevant to anyone working with individuals or groups of people, recognising as it does the need to be aware of a variety of potentially conflicting discourses:

any attempt at producing a discourse to promote health is challenged by other discourses, and the governance of society occurs within a constant struggle of conflicting interests

(Holmes and Gastaldo 2002 p560).

A number of authors have identified specific discourses within health including *discourses of anxiety* (Evans, Pereira and Parker 2008) through a psychodynamic exploration of the nursing ritual of the handover; a *discourse of moral suffering* (Paley 2004), arguing that "the meta-narrative that sustains nursing's identity also perpetuates it" (Paley 2004 p365); but the most penetrating opportunity that an analysis of discourse affords is that of exploring, identifying and highlighting the way which power relationships are established, maintained or resisted. Despite Traynor's reservations about the quality of some of the studies included in his review of the use

of Discourse Analysis in nursing research (Traynor 2006), he welcomes the interest in Discourse Analysis as a powerful means by which to

bring to light the operation of taken-for-granted practices in healthcare delivery that sometimes work to the disadvantage of patients or professionals themselves... [as well as the] ...status differentials between professional and patient"

arguing that Discourse Analysis offers

rigorous methods for providing evidence of how different groups achieve and maintain their status

(Traynor 2006 p70).

This emphasis on power relationships is taken up by Tilley and colleagues in their analysis of *discourses empowerment* (Tilley, Pollock and Tait 1999), in which they cite Swales' notion of a *discourse community* (Swales 1990) in referring to the *Big Stories* of policy in community psychiatric nursing and how these articulate with the *Little Stories* of practice within the discourses of empowerment of the practitioners themselves.

Whilst Discourse Analysis has been justified as a potentially rigorous research methodology for research in health (Traynor 2006), it is acknowledged that the term Discourse Analysis covers a wide range of approaches and epistemologies (Wetherell, Taylor and Yates 2001).

Traynor's overview of the application of discourse analysis as a research method in nursing from 1996 - 2004 identified 24 papers within one journal (Journal of Advanced Nursing) in which the authors stated that discourse analysis was among the methods or the sole method of data analysis (Traynor 2006). My own, less rigorous though wider-ranging, search of the literature undertaken for this current review would support his conclusion that:

the majority of papers cluster around critical approaches to discourse analysis. Only a few approach discourse analysis primarily as analysis of conversation. Some papers are excellent, while others offer analysis that bears little resemblance to any form of discourse analysis

(Traynor 2006 p62).

Examples of a number of forms of Discourse Analysis include:

- *Critical Discourse Analysis* (Crowe 2000; Fealy 2004; Reeves, Bowl, Wheeler and Guthrie 2004; Crowe 2005; Crowe and Luty 2005; Crowe 2006),
- *Bakhtian Analysis* (Harden 2000)
- *Conversation Analysis* (Lawless, Gale and Bacigalupe 2001; Perakyla and Vehvilainen 2003)
- *Frame Analysis* (Paterson 2007), deriving from the work of Goffman (Goffman 1974)

And the two approaches closest to the one pursued in the current study:

- *Social Constructionist approach to Discourse Analysis* (Potter and Wetherell 1987; Harper 1995; Tuffin, Tuffin and Watson 2001)
- *Foucauldian Discourse Analysis* (Wilson 2001) exploring surveillance discourses in child health nurses and (Heartfield 1996; Holmes and Gastaldo 2002; Darbyshire and Fleming 2008).

The application of this variety of forms of Discourse Analysis has generated some rich understandings of ways in which discourse shapes, and is shaped, by assumptions, practice and contexts in health. An example of the application of *Critical Discourse Analysis* (Wetherell, Taylor and Yates 2001), for example, explored the ways in which the nursing profession in Ireland conceptualised nursing and depicted ways in which the profession constructed its public image over time through the analysis of nursing periodicals (Fealy 2004). This approach enables Fealy to explore:

connections between language and the less transparent elements in social life, including the way that language works ideologically and is used to establish power and/or social identity

(Fealy 2004 p650).

Fealy's analysis concluded that

the image [of a good nurse] gradually changed from one that stressed the sort of person the nurse ought to be to one that stressed what the nurse ought to be able to do, and the lexicon of professional discourse reflected this.
(Fealy 2004 p655).

A similar approach has been used for a number of purposes by Crowe (Crowe 2000; 2005; Crowe and Luty 2005) including an analysis of the use of Discourse Analysis in nursing research as well as her own studies into an analysis on DSM-IV and the experience of depression.

Harden applied Discourse Analysis in her investigation of mature women's experiences of Project 2000 (Harden 2000). The autobiographical narratives of the women were deconstructed to reveal the discursive practices which shaped their subjectivities. The deconstruction employed a specific methodological tool borrowed from literary criticism – a *chronotopical* analysis, which situated the subject within specific discourses at specific time/space juxtapositions. She concluded:

nurses, whether practitioners or researchers, can undertake this form of 'narrative analysis' of others' life stories in order that the influence of dominant discourses can be identified. Patient histories or research narratives can be deconstructed to reveal the ideologies shaping the subjectivity of the respondent, regardless of their sex. The result will be an acceptance of the inherent contradictions which lie in remembered experiences.
(Harden 2000 p511).

Harper suggests that a *social constructionist approach to Discourse Analysis* can provide a fresh look at everyday practices like diagnosis within mental health (Harper 1995). His study explored two conversations that he undertook, one with a mental health professional and one with a service user, each of which produced a different discourse on the place of diagnosis in mental health from 'diagnosis is *useful*' from the mental health professional, to 'diagnosis is *useless*' from the service user. Harper argues that the former discourse could be seen as an empiricist account in that "psychiatric disorders are viewed as objective entities which are diagnosed

according to certain signs and which have certain courses and which then lead to certain psychological interventions” (Harper 1995 p351) whilst the ‘diagnosis is useless’ discourse could be seen as a ‘contingent’ account:

in that the diagnoser’s own investment and orientation is recognised... thus, through the use of a contingent discourse he resists and undermines the empiricist discourse by introducing his own personal agency and subjectivity into the narrative.

(Harper 1995 p352).

For the service user, the empiricist discourse is disempowering, leaving him/her with two options, either rejecting the discourse and talking in a different language or to subvert the discourses from within e.g. ‘I’m psychotic and proud’. “Positioning himself as ‘not sure’ in this case, the service user “enables him to live with a psychiatric diagnosis whilst still attempting to negotiate his own identity.”(Harper 1995 p353):

In mental health services there are a number of stakeholders’ voices which need to be attended to: professionals of various disciplines; users of services; users’ relatives; care staff; neighbours and so on. A social constructionist position would acknowledge that there are a variety of stories to be told, but, when linked to a political analysis we must also acknowledge that some stories (eg those of professionals) are more powerful than others (eg those of service users). The decision of how to deal with these stories is a political one.

(Harper 1995 p354).

In supporting Traynor’s argument that “some papers are excellent, while others offer analysis that bears little resemblance to any form of discourse analysis” (Traynor 2006 p62), my own search has identified a number of studies whose failure to articulate and justify the theoretical position underpinning the particular form of Discourse Analysis used expose them to the accusation suggested above that such studies lack rigour and therefore their findings cannot be considered valid. Powers, for example, provides a substantial account of Discourse Analysis in an American nursing context (Powers 2002). However, despite breaking her analysis down into three sections: genealogy, structural discourse analysis and a power analytic, the only framework she provides for her approach is reference to her own previous work. This is a significant weakness. Notwithstanding this important caution, she does

make some interesting propositions about the development of nursing discourse, suggesting that it has assumed the dominance of the language of 'empirical analytic science' and in so doing is ignoring the very voices whose sphere of influence it is seeking to highlight: that of the patients and their families. "We are using the language of science, professionalism and medicine to justify ignoring these voices" (Powers 2002 p961). This argument is persuasive but the apparent lack of rigour in describing and justifying her method and theoretical underpinning risk jeopardising it.

There is similar disappointment in the literature which claims to explore discourse within clinical supervision. Holloway and Poulin, for example, in describing clinical supervision, state:

it is an approach used in professional schools to inculcate the neophyte with the skills, attitudes and values of the profession... supervision is the discourse of teaching and learning... The dialogue created by the supervisor and trainee is a mirror of the process and thus has the potential to inform researchers of the character and evolution of supervision

(Holloway and Poulin 1995 p245-246).

This chapter is disappointingly riddled with assumptions and assertions, for example about where supervision is practised, by whom and in what manner, that are not set into context or justified and so does nothing to advance the argument for the place of discursive research practices.

Foucault's Discourse Analysis and clinical supervision

Some of the ways in which Foucault has articulated the productive nature of power relations have proved useful to researchers in this area. For example Holmes and Gastaldo likened the practice of modern nursing to Foucault's concept of *governmentality* (p19), commenting on nurses' perceptions of their powerlessness as the very discourse which makes feasible the systems that they believe source their oppression. They introduce the notion of *pastoral power* through the care of others:

pastoral power achieves care of others through various therapeutic regimes while ultimately helping to shape the self so that it fits within an appropriate, 'normalised' way of living. The normalised way of living refers to a conformity to a set of social rules and ways of conceiving oneself and others. The power of normalisation impose homogeneity by setting standards and ideals for human being

(Holmes and Gastaldo 2002 p560).

Citing Foucault, they conclude that “the strange secrets of the individual, exposed to professional scrutiny, are incorporated in expert professional discourses” (Foucault 1976-1984) cited in (Holmes and Gastaldo 2002 p562).

A Foucauldian approach to Discourse Analysis has also been found to be of particular interest where an analysis of the role of agency and subjectivity are being explored (Fournier 1998; Gilbert, Cochrane and Greenwell 2003). Armstrong (1993) has argued that this is particularly relevant to a health context (Mishler, Amarasingham, Osherson, Hauser, Waxler and Liem 1981; Armstrong 1993; 1997), particularly amongst what may be conceived of as less powerful groups such as service users (Speed 2006), psychiatric patients, (Hamilton, Manias, Maude, Majoribanks and Cook 2004), those with learning difficulties (Gilbert, Cochrane and Greenwell 2003) and as a means by which to analyse the potentially hegemonic discourse of reflective practice (Cotton 2001; Clouder and Sellars 2004; Rolfe and Gardner 2006) and other management processes (St-Pierre and Holmes 2008) . A Foucauldian approach has also been utilised in an analysis of the role of documentation in constructing a notion of ‘what is nursing’ and what role nursing plays in its own construction, concluding that the nursing profession is portrayed through documentation as ‘fragmented body work’ (Heartfield 1996 p102).

This section of the review has sought to justify discourse analysis as an appropriate methodology for researching health and, in so doing, has identified a number of themes that are relevant to the discourses of supervision. These include

- ways in which the ‘professional’ conceives of themselves and their relationship to professional identity and its discourses
- the role of the service user and their role within the delivery and receipt of care
- The potential subversive hegemony of an emphasis on reflective practice as a professional imperative

All of these issues concern themes of agency and subjectivity in relation to powerful groups and voices (the *discipline* and the *author* as outlined in the section on *Epistemes, discursive formations and the emergence of the human sciences* on page 17) and are relevant to the ways in which supervisors and supervisees see themselves in relation to their clients/patients, their organisations and their professions.

Review section two: research and academic literature on clinical supervision in mental health practice

The purpose of this section of the literature review is to identify the dominant themes and issues that are of concern to writers and researchers on clinical supervision. In turn, these concerns will inform the discursive frame as they indicate the nature of the content knowledge that is held within the *disciplines* and the *commentary* that experts in the field are applying to that knowledge, in line with a Foucauldian understanding of the way in which knowledge is constructed and managed.

Tsui’s review of the ‘State of the Art’ of research into post-qualifying social work supervision (Tsui 1997) identifies a number of aspects of supervision of concern to researchers. Whilst a number of other reviews of supervision research have been undertaken, notably within the fields of counselling, psychotherapy and in medical settings (Ellis, Ladany and Krengel 1996; Kilminster and Jolly 2000; Wheeler 2003),

Tsui's focus on *post-qualifying* supervision makes his review of particular relevance to the current study. Notwithstanding the limitations of Tsui's review, namely that it is situated within a North American social work context and it is now over a decade old, these eight aspects provide a suitable preliminary framework for the current literature review, focusing as they do, on *post-qualifying* supervision, whereas the findings of other reviews are strongly influenced by the much larger body of research into *trainee* supervision. In addition, Tsui helpfully highlights the lack of discussion of *culture* within the research literature. It also takes an inclusive approach to research methodologies and so includes a wider range of studies than those of reviews undertaken within the disciplines represented in this thesis (as argued in the rigour section of this literature review on page 47).

For this reason, in the review that follows, particular care has been taken to articulate the cultural and contextual implications of the research articles cited.

In the period under review (1970 – 1995), Tsui identified eight issues of concern to researchers:

1. supervisory functions
2. supervisory context
3. structure and authority
4. supervisory relationship
5. supervisory styles and skills
6. job satisfaction
7. training for supervisors
8. gender issues

In addition, one further section addressing research into the evaluation and efficacy of supervision is included as this theme emerged as an additional area of concern in

the literature identified in this study. So, the review will comprise Tsui's original eight concerns, as listed above, plus the two additional concerns:

9. Professional cultures and constraints
10. Evaluation and efficacy

1. Supervisory functions

There is wide agreement in the literature that the three functions of supervision, first identified by Kadushin (Kadushin 1992) and later popularised by Proctor (Proctor 1987) continue to have relevancy. Kadushin's early formulation of the supervisory functions of *education, support and management* (Kadushin 1992), more recently reconfigured by Proctor into the more familiar *normative, formative and restorative* functions (Proctor 1987) have been widely accepted within the literature on supervision, though Carroll's model of *functions and tasks* of supervision develops these into a broader range of functions (Carroll 1994). Several studies have recognised the need to maintain Proctor's three functions within clinical supervision and not to conflate them with either therapy (Yegdich 1999b) or managerial supervision (Yegdich 1999a). The benefit of the supportive function, as a private place in which to discuss caseload and practice issues, is recognised by Scott (Scott 1999). The formative function has been recognised in various ways including the importance of the 'structuring' facet of supervision (Clarkson and Aviram 1995) and the place of supervision as a means of personal development (Scaife unpublished). The normative function is epitomised in the need to ensure the delivery of a quality service to the client. (Orlans and Edwards 1997). Further evaluation of Proctor's model is included in the evaluation section of this review on page 81.

Reflective Practice

In addition to these almost ubiquitous three functions, the development of reflective practitioners (Schön 1983; 1987) has been enthusiastically taken up across the

health professions (Driscoll 2000; Bulman and Schutz 2008) and the place of reflection as being a central function of supervision is emphasised. The two processes (supervision and reflective practice) are often discussed together in the literature. This relationship was formally acknowledged in the NHS document *Vision for the Future*, asserting that clinical supervision “should be seen as a means of encouraging self-assessment and analytical and reflective skills” (DH 1993 p3) and reinforced by The NHS Plan (DH 2000). More recently, *Liberating the Talents* identifies the need to “give front line staff time to think creatively, reflect and learn” (DH 2002 p28). The role of reflective practice in the education of nurses is widely explored (Nicholl and Higgins 2004; Crowe 2006) for example, and its place within clinical supervision is given a comprehensive analysis by Cutcliffe (Cutcliffe 2003). There is much literature reporting work that explores the role of supervision as a place for reflective practice (Marrow, Macauley and Crumbie 1997; Maggs and Biley 2000; Landmark, Hansen, Bjones and Bohler 2003; Walsh, Nicholson, Kedugh, Pridham, Kramer and Jeffrey 2003; Launer 2004; McLean and Whalley 2004; Nicholl and Higgins 2004; Ralston 2005; Bégat and Severinsson 2006), each of them seeing the process of reflection in some way as “integral to personal change and, perhaps, compris[ing] the central feature of most evolving supervisory relationships” (McLean and Whalley 2004 p227), and “reflecting in and on practice is an essential part of this research study as it necessarily underpins the process of clinical supervision” (Marrow, Macauley and Crumbie 1997 p78). However, whilst each of these authors recommends the value of structured reflection within clinical supervision, there is little critique of the assumption that the process of clinical supervision *itself* is the most effective means to reflect on practice, and therefore to challenge, change or improve it. Cleary and Freeman’s 2005 study revealed that whilst nurses described the importance of reflective practice as a means to develop professional self-belief and individual growth, they did not attribute this to the process of clinical supervision specifically: “Reflective practices provided an opportunity to explore feelings, and

commonly nurses would seek to do this with colleagues through peer review, preceptorship programmes and discussion.” (Cleary and Freeman 2005 p495). Whilst findings from their ethnographic study emphasised strong support for and recognition of, the value of reflective practice, the mental health nurses in this study but did not necessarily associate this with clinical supervision. Rather, they reported being best able to reflect with peers, through preceptorship programmes and in ad hoc discussions with colleagues. “They also provide a daily opportunity to reflect on reactions to the patient, the nature of professional relationships, and nursing strategies without creating stress due to time taken away from unit duties.” (Cleary and Freeman 2005 p499). In addition, an analysis of the experiences of clinical supervision with registered nurses in Ireland found that *reflective practice sessions* were more appropriate to this context than clinical supervision as such (Kilcullen 2007).

2. Supervisory context

As indicated above, perhaps the most commonly recurring problem within much of the literature on supervision is the lack of consideration given to the influence of context. Whether this is through an attempt to make the literature of interest to as wide an audience as possible or whether, through genuine lack of insight, much of the literature appears happily to disregard the effect of context on the practice of supervision, therefore limiting what can be said about it of relevance to other contexts. The most frequent conflation is in respect of research from the United States and parts of Australia and New Zealand where the assumption is normally made, though rarely articulated, that supervision takes place exclusively in the training environment and not in post-qualifying contexts.

However, there are some interesting exceptions to this where researchers have made specific attempts to identify the cultural and contextual influences on the

practice of supervision (Fukuyama 1994; Cleary and Freeman 2005; Waskett and Shone 2006). Cleary and Freeman, for example, used an ethnographic approach to explore the cultural realities of clinical supervision within the context of an Australian mental health nursing setting. Their findings suggested

that there is verbal acceptance of CS [clinical supervision] by mental health nurses but a cultural belief that it has limited experiential value and, thus, a cautious attitude towards its adoption in practice.

(Cleary and Freeman 2005 p489)

They also suggest that:

despite a decade of discussion about the potential benefits of CS, there continues to be concern about nurses' understanding of CS and the pragmatics of implementing models of supervision appropriate to the profession, its speciality and locality.... Informal, ad hoc approaches to preventing boundary transgressions were viewed by nurses to be more responsive to current clinical circumstances despite the promotion of clinical supervision as a means of ensuring that staff practise in an 'ethical manner' ... There was a generally held belief that for clinical supervision to be beneficial, it should not be mandatory, particularly group supervision" ... Although nurses believed CS was a good concept for reflective practice and professional growth', and were supportive in principle, most were ambivalent about making a commitment and found it difficult to create space for it within their daily work. They did not actively pursue individual CS opportunities and questioned its feasibility, identifying 'time and staffing levels' as constraints.... 'in reality it just isn't feasible and doesn't work'"

(Cleary and Freeman 2005 pp492 - 498).

They describe a culture of 'passive resistance' amongst the nursing profession.

In his small-scale phenomenological study of Macmillan nurses, Jones argues:

Nursing has, arguably, eschewed supervised practice, associating it with failure and weakness. Nonetheless, being always knowing, forever strong, constantly giving and never needing oneself, are anachronisms in the face of demands of contemporary nursing practice. Such ways of thinking, however, make up powerful professional myths that are unlikely to be successfully challenged without encountering resistance.

(Jones 2000 p28).

This perceived attitude amongst (some) groups of nurses cannot be assumed to apply to practitioners from other professions, or indeed to all nurses, but the apparent

reluctance of nurses to engage in clinical supervision is a substantially recurring theme and one which has relevance to this study.

The particular contextual constraints to be found within the UK National Health Service have more recently started to be identified by researchers. Brocklehurst and Walshe, for example, provide a useful overview of implications of NHS reforms (Brocklehurst and Walshe 1999), and an increasing body of recent writing on clinical supervision, particularly in the nursing literature, has made the connection with *clinical governance*, and the opportunity afforded for the promotion and delivery of clinical supervision within this context (Bowles and Young 1999; Joyce 2001; McLean and Whalley 2004).

Other studies which have identified the implications of specific contexts for the practice of supervision include that undertaken by Coleman and Lynch, who recommend clinical supervision as a way to reduce isolation in rural communities for community nurses and Cutcliffe who echoes the same recommendation in relation to community psychiatric nurses (Cutcliffe 2005; Coleman and Lynch 2006).

These studies, which make explicit the contexts within which they have been conducted, are in the minority. It is to be regretted that many widely cited studies fail to do this and so undermine their validity.

3. Supervision structure and authority

Three distinct structures for the practice of supervision have been identified in the literature: individual, group supervision and multi-disciplinary/cross-disciplinary supervision.

Individual and group supervision

Whilst individual supervision is seen as the norm, other formats for supervision have been explored (Milne and Oliver 2000), group supervision being the most frequently practised alternative. A perception exists that group supervision can provide additional benefits to the participants over individual supervision. For example, Proctor has developed the Group Supervision Alliance Model (Proctor 2000) as a reformulation of the earlier Supervision Alliance Model developed with her colleague, Inskipp, (Inskipp and Proctor 1993; 1995; Proctor 2000). This latter model offers practical guidelines for four overlapping but distinct types of groups: authoritative, participative, co-operative and peer, though these proposals are not drawn from evidence, rather they are derived from a theoretical perspective on group dynamics. Group supervision as a means of facilitating learning among students was explored by Saarikoski and colleagues (Saarikoski, Warne, Aunio and Leino-kilpi 2006). However, research evidence does not always support the assumption of its benefits. Williamson and Dodds (1999) undertook a review of the literature on the effectiveness of group supervision as a means of reducing stress in nurses and found only one study, the work of Butterworth and colleagues that could provide any evidence for this (Butterworth, Bishop and Carson 1996; Butterworth, Carson, Jeacock, White and Clements 1999). Others, however, claim that group, or team, supervision is helpful in enhancing collaboration between members, sharing experiences and improving team work (Hyrkas and Appelqvist-Schmidlecher 2003). Arvidsson et al. reported a pronounced professional identity and nursing care perspective after a two-year group supervision programme (Arvidsson, Lofgren and Fridlund 2001)., whilst Walsh and colleagues present a case study of the implementation of a group model of clinical supervision. In discussing the case study, the authors emphasise the benefits of a group model in terms of developing

reflective practice although also reporting that the intention of the participants to create a supportive environment worked against an atmosphere of challenge and critique (Walsh, Nicholson, Kedugh, Pridham, Kramer and Jeffrey 2003). Cleary and Freeman's ethnographic study with Australian mental health nurses undertook supervision in an 'open group format' in which the membership is fluid. They articulate some of the potential disadvantages of this system: "a reluctance to self-disclose, an absence of focus, and repetition of content" (Cleary and Freeman 2005 p500). This reluctance to disclose is also highlighted in a study by Webb and Wheeler (Webb and Wheeler 1998). Berg and Hallberg's study of clinical group supervision came to a similar conclusion in suggesting that group supervision was limited in relation to the honesty in which nurse participants expressed their thoughts and feelings (Berg and Hallberg 2000). Perhaps the proposition of Winship and Hardy (1999) offer the most persuasive argument for the benefits of group supervision over individual supervision arguing that an understanding of group theory and an experience of interpersonal relationships through the working of a supervision group can prepare nurses for dealing with conflicts in clinical practice (Winship and Hardy 1999). Stevenson and Jackson's (2000) experience of Egalitarian Consultation Meetings, also suggest that non-hierarchical groups can provide an environment within which existing policy and practice can be challenged (Stevenson and Jackson 2000; Stevenson 2005).

Multi-disciplinary/cross-disciplinary supervision

As noted by Colyer:

Since the early 1990s, there has been a strong political imperative in the UK to develop existing roles in nursing and the allied health professions, blurring professional boundaries and emphasising patient/client centred care delivery. This has already led to major changes in professional work patterns and the privileging of interprofessional work.

(Colyer 2004 p406).

These changes are also reflected in the practice of clinical supervision where some have advocated its usefulness as a means of promoting and supporting interprofessional practice (Mullarkey, Keeley and Playle 2001; Hyrkas, Appelqvist-Schmidlecher and Paunonen-Ilmonen 2002; Hyrkas, Appelqvist-Schmidlecher and Haataja 2006; Jones 2006). Mullarkey, Keeley and Playle argue that:

it is not necessarily the type of clinical supervision model that is used but the way it is used that is important to its transferability between professionals
(Mullarkey, Keeley and Playle 2001 p209)

concluding that:

it may be that supervision with a colleague from another discipline may add to the constructive challenging nature of supervision, as taken-for-granted assumptions within a professional group may require clarification.
(Mullarkey, Keeley and Playle 2001 p210).

Notwithstanding the important differences between multi-disciplinary and interprofessional working within the practice of supervision, any format in which members of one profession are supervising, or supervised by or with, members of another profession is included here. Townend (2005) argues that successful interprofessional working in general relies on the parties having roughly equal power. In the case of mental health nursing, he argues, it “has traditionally lacked professional power in relation to psychiatry and also to a certain extent clinical psychology” (Townend 2005 p583). So, whilst the intention behind multi-disciplinary supervision may be to enhance interprofessional working and understanding, perhaps it may actually serve to promote and perpetuate the traditional hierarchies. Indeed, in Townend’s own study, results showed that whilst there appeared to be interprofessional supervision taking place, it was not in equal balance. For example while a total of 36 psychologists supervised colleagues from other professions, only 5 psychologists were, in turn, supervised by colleagues from other professions. And while 29 nurses were supervised by members of other professions (of which 22 were

psychologists), they, in turn only supervised 7 members of other professions, only 1 being a psychologist (Townend 2005).

Authority of Supervision

In 1992, Butterworth and Faugier first published their *Clinical Supervision and Mentorship* in Nursing, now in its second edition (Butterworth and Faugier 1998). At the time of their writing, the authors were hopeful that the three emerging processes of mentorship, preceptorship and clinical supervision would continue to grow and develop within nursing. In fact, what appears to have happened is that there has been some conflation of the processes, and some confusion as to the professional body's requirements and recommendations about each. Some of the literature on mentorship, for example, could equally be relevant to the practice of supervision (Spouse 2001; Beecroft, Santner, Lacy, Kunzman and Dorey 2006). In the years since publishing their book, both 'mentorship' and 'preceptorship' have gained authority through the requirements for supporting and assessing student nurses in practice, but 'supervision' has lost ground, not being mandatory practice either pre- or post-qualification.

The relative authority and responsibility of the supervisor vis-à-vis the supervisee has been of particular interest to the counselling profession. Whereas nursing and clinical psychology are more often undertaken within an organisational context with their own hierarchies and accountability processes, counselling is more often practised in the private or voluntary sector, making issues such as accountability and authority within the supervisory relationship more acute. Within this context, King and Wheeler (1999) undertook a qualitative study into whether counselling supervisors considered themselves to be clinically responsible for their supervisees.. Their study suggests that this is not how the supervisors would describe their

responsibilities, though they also found that supervisors practised a form of self-protection against potential threats in respect to their responsibility in that they tended to be reluctant to take on newly qualified supervisees or supervisees that they did not already have confidence in, thereby avoiding those supervisees who may seem higher risk.

4. Supervisory Relationship

I have yet to find a study that explores the nature of 'good' supervision that does not rank the quality of the relationship as one of the foremost, usually *the* foremost criteria (Martin, Newton and Goodyear 1987; Fortune and Watts 2000; Kilminster and Jolly 2000; Lawton 2000; Cottrell, Kilminster, Jolly and Grant 2002; Jones 2006). The literature review undertaken by Kilminster and colleagues found that:

the supervision relationship is probably the single most important factor for the effectiveness of supervision, more important than the supervisory methods used.

(Kilminster and Jolly 2000 p827).

Most such studies are qualitative in nature and use the supervisors' and/or supervisees' comments, perceptions and responses as the focus. Efstation, Patton and Kardash (1990) developed their *Supervisory Working Alliance Inventory* through a mixture of qualitative and quantitative methods, though their data still derives from the participants' *perceptions* of the supervisory relationship, as opposed to any externally observable qualities.

Several studies suggest that a high quality supervisory relationship is characterised by one where confidentiality is assured (Cutcliffe and Hyrkäs 2006), and which is kept separate from managerial/administrative supervision (Cutcliffe and Hyrkäs 2006). Webb and Wheeler's (1998) study into the level of honesty expressed by counsellors in supervision found a

positive correlation between the quality of the supervisory working alliance as experienced by the supervisee and the extent of his or her disclosure.
(Webb and Wheeler 1998 p 509).

Where clinical supervision is conflated with managerial supervision, this characteristic of a high quality relationship may be jeopardised as there may be explicit or implied pressure on the supervisor to break confidentiality where potential management issues are revealed, or on the supervisee to resist disclosing information that could expose them to managerial intervention.

Whilst the importance of the supervisory relationship is consistently asserted and reinforced not least by the sheer quantity of studies carrying the same message, concerns persist about the lack of critique of what constitutes 'good' supervision. The fact that supervisees and supervisors alike consistently rank the quality of the relationship very highly does not automatically create a causal link between a high quality relationship and good supervision, not least because the criteria for what makes supervision good are arguable – good for *whom*? Good for *what*? (See below, in the *Evaluation and efficacy of supervision* section on page 81, for more discussion on this.)

5. Supervision styles and skills

A spectrum of supervisory styles has been reported in the literature. Long, Lawless and Dotson devised the *Supervisory Styles Index* from their own research into supervision within Family Therapy (Long, Lawless and Dotson 1996). This index was developed in order to provide supervisors with an instrument to begin to examine their own supervisory style. Three sets of complementary supervisory styles were identified: *affiliative and authoritative; non-directive and directive; and self-disclosing and non-self-disclosing*. This particular study explored gender differences in perception of supervisory style and found only one such difference, in that female

supervisees tended to rate supervisors as more self-disclosing than male supervisees. Heron's Six Category Intervention Analysis has been adopted by Driscoll (Driscoll 2000) as a further means to identify supervisory styles. Heron's six categories are a model by which the style of therapeutic intervention can be assessed. They range from the *authoritative* (prescriptive: giving advice; informative: imparting information; confrontational: directly challenging) to the *facilitative* (supportive: understanding and encouraging; cathartic; allowing the release of emotions; catalytic: encouraging deeper exploration).

The review also identified four other sets of studies related to supervision styles and skills:

- Supervisory styles and leadership
- Role modelling
- Supervisory style as a reflection of therapeutic orientation
- Supervisory skills

Supervisory styles and leadership

Supervisory styles have also been associated with leadership styles, particularly in some of the Scandinavian research into clinical supervision (see Sirola-Karvinen and Hykas 2006 for example). In these studies, clinical supervision has been explored as a means by which nurses can develop leadership skills. For example, Severinsson and Hallberg looked at supervisors' views of their leadership role in the delivery of supervision. Through interviews and questionnaires of 18 trained nurse supervisors, their findings suggest that they were themselves influenced by role models of supervisors they had, themselves, encountered in their experience (Severinsson and Hallberg 1996). In the UK, too, Johns (2003) has written on the place of supervision for nurturing leadership in nursing. Whilst the establishment of clinical supervision was seen as a "developmental opportunity to develop clinical leadership" (Johns

2003 p33) in reality, he found that this opportunity was constrained by organisational cultures.

Role modelling

This recognition of supervisors as role models has, perhaps unsurprisingly, been widely reported in the literature: “nurse supervisors acted as role models... sharing both nursing knowledge and ethical codes.” (Berggren and Severinsson 2003 p621). In their hermeneutic interpretation of nurse supervisors’ ethical decision-making styles, the same team found this has an impact on the outcome of the supervision in terms of being a role model (Berggren and Severinsson 2006). Focusing primarily on the development of ‘ethical competence’, their findings highlight four important values for ethical decision-making: caring, dignity, responsibility and virtue. The first of these two studies was very small scale (4 participants) and the later one, generated no new data but derived its argument from the findings of the earlier piece, together with other studies undertaken by the same team. Whilst this does not invalidate the very interesting findings and suggestions raised, they need to be considered within their distinct context and the very small-scale nature of this project. Ethical decision-making was clearly a specific interest of this team, and they were looking to understand more about it.

Supervisory style as a reflection of therapeutic orientation

As indicated above, therapeutic orientation and supervisory style have long been connected, due in part to the fact that much of the early literature to emerge on the topic of supervision derived from therapeutic assumptions around the concepts of transference and counter-transference and the parallel process (Mattinson 1992). Perhaps unsurprisingly, this emphasis is more prevalent in the counselling literature than in that of other health professions (Issacharoff 1982; Friedlander, Siegal and

Brenock 1989) where there is a certain cautiousness in likening the supervision process to the therapeutic process (Yegdich 1999b). This is much less of a concern in the counselling literature.

This proximity to therapeutic approaches provides counselling supervisors a relatively straightforward means by which they can underpin their practice with theory. Berg and Kisthinos(2007), on the other hand, explored theoretical approaches amongst nurses and found many supervisors (a quarter of those surveyed) did not state a nursing theoretical perspective. However, a supervisor's theoretical perspective has not always been found to be helpful to the supervisory process. A very interesting study by Gazzola and Therialut (2007) found that supervisors who "rigidly adhered to their own theoretical orientation" could have a *narrowing* effect on the supervision process, whilst supervisors who gave constructive feedback and who invited supervisees to participate in conceptualising their cases" enabled a beneficial *broadening* effect for the supervisee (Gazzola and Theriault 2007 p200).

Supervisory skills

More specific supervisory skills have been highlighted in a number of studies. For example, In their illuminative evaluation investigating the reciprocal interpersonal interactions between clinical supervisors and their supervisees, Sloan and Watson (2001a; 2001b) identified a number of recurring interventions including taking the lead, suggesting an option, exploring the supervisee's work, reflecting back, conveying an understanding of client issues, being supportive and giving information. and demonstrated how these might helpfully relate to Heron's categories, referred to on page 69.

6. Job satisfaction (and burnout)

Clinical supervision has been seen as a means by which work stress can be reduced and job satisfaction enhanced (Jerrell 1983; Berg and Hallberg 1999; Graham 1999; Hancox, Lynch, Happell and Biondon 2004; Hyrkas 2005; Cleary and Freeman 2006; Hallin and Danielson 2008). Berg and Hallberg (1999) used a pre-post test design, based on a number of pre-existing scales, to explore the effects of a year of systematic clinical supervision on psychiatric nurses. Their findings indicated that the supervision programme “led to a significantly increased creative and innovative climate in the dimensions for trust, idea time and reduced conflicts” (Berg and Hallberg 1999 p371); though their standardised measures failed to demonstrate any significant changes in occupational stress, job strain, and sense of coherence of job satisfaction. Hancox, Lynch, Happell and Biondo (2004) refer to this work by Berg and Hallberg as a background to the implementation of a supervisor education programme for mental health nursing in Victoria, Australia. Clearly, if the finding that efficient supervision is, indeed, correlated to increasing job satisfaction, then the argument for further investment in the education of clinical supervisors is persuasive. However, Tilley and Chambers (2003) point out that that research findings on clinical supervision and burnout are inconclusive and based on several small-scale Scandinavian studies, including the two referred to above. In their own investigation into the notion that clinical supervision can reduce stress and burnout, these authors refer to the Clinical Supervision Evaluation Project (Butterworth 1997; 1999) which hypothesised that high scores on the Manchester Clinical Supervision Scale may be associated with lower levels of burnout. Being based on a much larger sample, and British, Tilley and Chambers argue that the findings of this would be more robust for a British context. However, Tilley and Chambers’ 2003 paper is only able to report work in progress and no final report of this work can be located.

Hyrkäs is also critical of the works of Berg and Hallberg, of both the study referred to above, and two earlier studies (Hyrkas 2005). She argues that the small sample sizes, together with methodological problems and dual role as researcher-supervisors may have affected the findings. Hyrkäs' own study surveyed a much larger and more disparate group of Finnish mental health and psychiatric nurses. Her findings seemed to demonstrate that efficient clinical supervision was related to lower burnout, and inefficient supervision to increasing job dissatisfaction. Interestingly she also reports that acting as a supervisor for others had a significant influence on job satisfaction, and their burnout scores were also lower than their non-supervising colleagues. Incidentally, she claims this study was an evaluation of the current *state* of clinical supervision, though in fact it is the supervisees' *own* evaluations of clinical supervision. This is reflective of the recurring problem identified in the section on the supervisory relationship on page 68, in that much research into clinical supervision produces findings that are based purely on *self-report* and *perceptions* which, while extremely valuable, would be more robustly justified if supported by data from other sources, such as the external observation of practice.

Supervision has a long tradition of being seen as a place for managing anxiety (Menzies 1960). This is also emphasised by Cutcliffe in arguing for the provision of clinical supervision for those working in isolated contexts, such as community psychiatric nurses (Cutcliffe 2003). It also implicitly alludes to the therapeutic potential of supervision. There is much debate about the need to keep therapy and supervision separate (Yegdich 1999b). Nonetheless, therapeutic elements *are* seen as relevant to supervision, usually justified in terms of being those aspects that may have an effect on the work of the supervisee. In his research into the experience of supervision amongst Macmillan Nurses, Jones argues for the therapeutic functions of supervision:

Macmillan nurses brought themselves, and so their personal and professional selves, to supervision.... The safe and effective delivery of care to patients is... inextricably linked to the personal well-being of nurses.

(Jones 2000 p27)

7. Training for supervisors

The relative lack of training for supervision is widely recognised in the literature (Russell and Petrie 1994; Fowler 1996). There appears to be an assumption in practice that an experienced practitioner has the necessary skills and experience to offer clinical supervision. Perhaps this is unsurprising given that the impact and evaluation of such training is also unconvincing. Milne and James' (2002) study into the observed impact of training on competence in clinical supervision came to the tentative conclusion that competence in supervision appeared to require training. Using an observational instrument they coded over one thousand interactions between supervisors and supervisees and marked improvements were noted following training, though the authors themselves note some substantial reservations in the conclusions that can be drawn from their findings. It is clear that there is a lack of research in this area and there is much scope for further exploratory studies.

8. Gender issues

Despite Tsui's assertion that gender issues are one of only eight issues of concern to researchers into supervision in social work, suggesting it is of major concern (Tsui 1997), very little literature on this in the health professions was identified in this review. To date, only two pieces have been found which explicitly explore the issue of gender, both from within the field of Family Therapy, in which gender is a central theme (McHale and Carr 1998; Moorhouse and Carr 2002). Both studies look at conversational behaviour of supervisors and their supervisees (all trainees in this context). The earlier study reported that:

female supervisors used a directive style more commonly than did male supervisors. They tended to interrupt trainees more and made more declarations of opinions as facts... Trainee therapist gender had no effect on supervisor discourse style... male trainees used more humour

(McHale and Carr 1998 p407-408)

However, the authors themselves are cautious of drawing conclusions from these findings, recognising the specificities of the context, training and selection factors. The later study, undertaken by one of the same authors (Carr) and colleague, suggests that:

the way supervisors interact with therapists and therapists interact with clients does not conform to gender stereotypic conversational behaviour in which males are directive and females affiliative.

(Moorhouse and Carr 2002 p46)

They recognise that it may be that individuals whose conversational behaviour does not conform to gender stereotypes may be the very people who

decide to become family therapists or that family therapy training helps people develop alternatives to gender-stereotypical conversational behaviour
(Moorhouse and Carr 2002 p46).

Other research concerns

Whilst Tsui's framework (Tsui 1997) has provided a helpful starting point from which to gain an overview of the research concerns in clinical supervision, many of which are reflected in the discourse analysis that follow and will, therefore be picked up again in the discussion chapter, there are a number of other concerns of relevance to the health professions that do not fit within Tsui's frame. These primarily derive from contextual factors related to the influence of professional cultures and constraints. There is also an emerging, though still small, literature on the evaluation of clinical supervision.

9. Professional cultures and constraints

The profession of nursing is arguably the one which has researched the concept, nature and practice of supervision more effectively and over a longer period of time than any other health profession, as illustrated by Rafferty and Traynor, who comment on the relatively recent and rapid growth of nursing research in general

through their assessment of nursing research output with reference to the rise in RAE (Research Assessment Exercise) citations and funding sources (Rafferty and Traynor 2006). Research in and about clinical supervision has been undertaken in a number of specific branches of nursing, including Macmillan Nursing (Jones 1998; 2000) adult, child, learning disability and mental health branches (Davey, Desousa, Robinson and Murrells 2006) and community psychiatric nursing (Hill 1989). Despite the predominance of representation from the nursing profession in the field of research into supervision, the practice of supervision within nursing is still not universally provided or accessed, though more so in mental health nursing than the other branches. As indicated above, the counselling profession has been instrumental in the development of many of the concepts and practices of supervision which have, in turn, influenced the practice of supervision within nursing and clinical psychology, a newer profession. Being much smaller professions, however, the quantity of research being undertaken within counselling and clinical psychology is significantly smaller. Unlike the place of supervision in nursing, counselling and psychology supervision is widely accepted and espoused by practitioners at every level, arguably at the expense of a more critical approach to the benefits and potential hazards related to its practice.

Professional Identity

A 'pronounced' professional identity and an integrated nursing care perspective was reported in a study of the effects of a group supervision programme, by Arvidsson and colleagues (Arvidsson, Lofgren and Fridlund 2001). The participants reported that these enhancements persisted four years after the implementation of the programme. The notion of developing a professional identity is highlighted again in two more recent pieces, from the same team in Scandinavia: (Berggren and Severinsson 2003; Berggren, Barbosa da Silva and Severinsson 2005), the later

work reporting that “it is through communication with other nurses that the nurse supervisee develops her/his professional identity” (Berggren, Barbosa da Silva and Severinsson 2005 p26). Other Scandinavian studies that have also identified the development of professional identity perspectives through the process of supervision include Arvidsson and Fridlund (2005) as well as Solbrekke and Jensen (2006). This latter study looked at moral philosophy to explore the learning processes of two student groups namely, nurses and psychologists and identified the concept of *moral commitment* to their espoused profession among students. Within the British context, Jones suggests that:

clinical supervision offers possibilities for reaching the essence of nursing practice... opportunities to talk about experiences gave all Macmillan nurses a protected space in which to make sense of their internal words and so relocate people and events appropriately.

(Jones 2000 p27).

Implementation of clinical supervision

Despite this, albeit small, literature on the potential for clinical supervision to enhance a sense of professional identity in nursing, the literature also reveals persistent obstacles in the implementation of clinical supervision in that professional context (McKinlay and Pegram 1999; Malin 2000; Cleary and Freeman 2005; Davey, Desousa, Robinson and Murrells 2006; Rice, Cullen, McKenna, Kelly, Keeney and Richey 2007). Similar obstacles are not so apparent within the professions of clinical psychology or counselling (Bishop 1998), though one early study of the provision of clinical supervision for clinical psychologists within an NHS Trust in the North West of England does raise concerns about an apparent lack of provision for this community (Gabbay, Kiemle and Maguire 1999). Desousa and colleagues, in their large-scale study of the clinical supervision provision for nurses of all branches 18 months after qualification, report that “sizeable proportions of nurses had never had a clinical supervisor in their current job” (Davey, Desousa, Robinson and Murrells 2006 p237), and this despite numerous policy drivers from the Department

of Health, particularly under their Agenda for Change and the related Knowledge and Skills Framework (DH 2006c).

A number of reasons for these obstacles to implementation are proposed, including resistance from nurses themselves, a lack of resource provision and commitment by the organisation and a lack of high quality supervision. Cleary and Freeman (2005) suggest that one of the potential reasons for ambivalence amongst mental health nurses for the practice of clinical supervision over other professional support strategies may be because:

it is difficult for nurses to overtly identify themselves as stressed or not coping, and formal attendance at clinical supervision could be perceived as an admittance of this

(Cleary and Freeman 2005 p499),

indicating that arguments, as outlined in sections above, highlighting the benefits of clinical supervision as a means of reducing stress and burnout may, actually, be counterproductive in the message it gives to nurses. There is an apparent irony in this. If it is, indeed, the case that clinical supervision can enhance a sense of professional identity for nurses, an aspect of that very professional identity is that they are 'copers' and do not need formal opportunities to manage their emotional stresses and so are resistant to the offer of clinical supervision. In their evaluation of a clinical supervision education programme, Hancox and colleagues (2004) suggest that their programme has been "effective in influencing the attitudes of the nurse participants towards CS", arguing that an education programme can be useful as:

a means to address misconceptions many nurses hold about CS and subsequently the apprehension they develop towards it.

(Hancox, Lynch, Happell and Biondon 2004 p202).

Spence and colleagues (2002) report on their 'collaborative' approach to implementation which, they argue, can contribute towards successful implementation as it involves all stakeholders in its planning and delivery. Driscoll (2000), in his

practical handbook for nurses, *Practising Clinical Supervision*, attempts to overcome any potential resistance towards clinical supervision by suggesting that much of what takes place in clinical supervision will already be occurring within nursing practice, recommending his book on the grounds that it will help “you recognise things that already go on in your practice that may mimic clinical supervision” (Driscoll 2000 introduction).

An alternative view is proposed by White and colleagues (1998). Their suggestion is that, rather than clinical supervision being resisted by nurses themselves, it is the lack of investment by NHS Trusts that creates an obstacle to its implementation. Their study, part of which included an exploration of the experiences of nurses engaged in clinical supervision, showed respondents reporting:

an enthusiasm to talk meaningfully to a trusted colleague.... such opportunities were particularly welcomed by nurses who wished to reflect upon their practice with patients, especially when dealing with their clinical conditions which were upsetting, or otherwise challenging and sometimes harrowing.

(White, Butterworth, Bishop, Carson, Jeacock and Clements 1998 p185)

These findings, suggesting that “a happy nurse is a happy patient” (White, Butterworth, Bishop, Carson, Jeacock and Clements 1998 p191) are proposed by the authors as one of several reasons why NHS Trusts should adequately resource the provision of clinical supervision. The cost implications of an implementation programme were also highlighted by White and Winstanley (2006), albeit within an Australian context. They concluded that the cost of giving peer, group, one-to-one supervision to any nurse represented about 1% of an annual salary. The need to convince managers that this cost can be justified as an inherent part of nursing work, and the difficulty in so doing given the lack of evidence identifying demonstrable benefits in terms of patient care was highlighted, though it may be significant that their study was undertaken over a decade ago, and not in the UK, therefore it takes

no account of the impact of initiative such as Agenda for Change and other policy drivers in the NHS.

A further reason for problems with implementation is suggested by Scanlon and Weir (1997), in their small-scale qualitative inquiry into mental health nurses perceptions and experiences of clinical supervision. The authors found that “good enough supervision was more the exception than the rule” (Scanlon and Weir 1997 p295), suggesting that, while nurses reported a positive perception of the opportunities afforded by clinical supervision, the inconsistent quality of provision could have an impact on attitudes towards its effectiveness. The lack of training and preparation for supervisors is also highlighted by Fowler (1996) in his review of the literature. The lack of research into the effectiveness of supervision training was noted earlier on page 75.

10. Evaluation and efficacy of supervision

Evaluation into the effects of clinical supervision is notoriously difficult to achieve, not least because the client/patient whose better care is the ultimate aim of supervision never directly participates in its practice (except in the practice of Family Therapy, which is beyond the scope of this current study).

As indicated above (see *Supervisory Relationship* section on page 68), supervisee perceptions of what makes a good supervisor, are not necessarily indicative of what makes for good supervision, either in terms of ultimate benefit to the client, or even in terms of what’s ‘best’ for the development of the supervisee. Caution should be taken in too readily applying evaluation findings which derive from supervisee perceptions only. This is another area where there is much scope for further research.

‘Good’ supervision

The Manchester Clinical Supervision Scale, developed by the School of Nursing at the University of Manchester (Winstanley 2001) provides the most widely-used framework for evaluating the process of clinical supervision, deriving as it does from the largest-scale evaluation project yet undertaken in the UK: the Clinical Supervision Evaluation Project (Butterworth, Bishop and Carson 1996; Butterworth, Carson and White 1997; Butterworth, Carson, Jeacock, White and Clements 1999). However, it is important to recognise that this scale provides a tool for the recipients of supervision (the supervisees) to evaluate their supervision, not as a means to evaluate the effectiveness of supervision for the patient/client/service user. An example of the use of this scale to evaluate clinical supervision is the study of Edwards and colleagues undertaken amongst community mental health nurses in a Welsh NHS Trust (Edwards, Cooper, Burnard, Hannigan, Adams, Fothergill and Coyle 2005).

Their study concluded that clinical supervision was:

more positively evaluated where sessions lasted over one hour, and took place on at least a once-monthly basis. Perceived quality of supervision was also higher for those nurses who had chosen their supervisors, and where sessions took place away from the workplace.
(Edwards, Cooper, Burnard, Hannigan, Adams, Fothergill and Coyle 2005 p405).

Sloan (1999), in his study to identify what makes a good supervisor, also found that having a supervisor allocated to them or having one’s manager as one’s supervisor “and having supervision sessions documented and stored by this manager, all threatened the full utility of the clinical supervision” (Sloan 1999 p713).

Severinsson and Borgenhammar (1997), through interviews and a grounded theory approach, found that:

clinical supervision is an integration process guiding a person from ‘novice to expert’ by establishing a relationship of trust between supervisor and supervisee

(Severinsson and Borgenhammar 1997 p175).

Additionally, they found that the implementation of systematic clinical supervision may positively affect quality of care, patients' recovery, create improved feeling of confidence in one's work, and prevent burnout among staff. However, it is possible that this finding may have been influenced by the nature of the sample interviewed, selected as being 'experts' in their field. These findings were derived only from the views of a small number of these 'experts' and not from any kind of evaluation of supervision itself.

Sloan (1999) used a questionnaire and focus group methodology with mental health nurses to identify characteristics of a good supervisor from a supervisee perspective:

The ability to form supportive relationships, having relevant knowledge/clinical skills, expressing a commitment to providing supervision, and having good listening skills were perceived....as important characteristics of their supervisor

(Sloan 1999 p713).

Teasdale and colleagues (2001) undertook a survey drawing on an 'opportunity sample' of 211 qualified nurses from 11 randomly selected hospital and community NHS Trusts in England. Quantitative data was collected using the Maslach Burnout Inventory (MBI) and the Nursing in Context Questionnaire (NICQ) while qualitative data were based on written critical incidents. NCQI detected that supervised nurses reported a more listening and supportive management, coping better at work and feeling that they had better access to support than unsupervised nurses. This positive finding was particularly strong among the more junior supervised nurses, leading the authors to suggest that where resources are limited, it is better to concentrate on providing clinical supervision to more junior nurses (Teasdale, Brocklehurst and Thom 2001).

A further study into supervisee perceptions of good supervision was undertaken by Smith and colleagues in a social work context (Smith 2000; Smith, Nursten and

McMahon 2004). When asked about their most desired responses from the 'ideal supervisor', responses included:

the supervisor 'being there' for the supervisee, having time for them, listening and not criticising. Understanding, acknowledging, recognising the supervisee's position and what had happened and offering the opportunity for a non-judgemental exploration were highly valued. Validating, affirming, confirming and supporting the supervisee were also seen to be of importance.... Humanity, warmth and non-critical appreciation were seen as being far more important than theoretical knowledge and/or technical skill.
(Smith, Nursten and McMahon 2004 p556)

Smith et al conclude that:

if social workers feel that their fears are acknowledged, taken seriously and thought about in their working lives they are more likely to be more satisfied, likely to stay in the profession for longer, and service-users will get a better service.
(Smith, Nursten and McMahon 2004 p558).

Whilst this example is taken from social work, it is included as it is one of very few studies that makes claims about the benefit of supervision to the client, though this is still speculative and not well justified.

A more convincing attempt to make connections between supervisee perceptions and client outcomes was undertaken by Jones, whose phenomenological study of Macmillan nurses explored beneficial changes derived from clinical supervision (Jones 1998; 2000). His claim for the benefit to patients is based on the assumption that the personal wellbeing of nurses is a pre-requisite for safe care of patients.

Whilst this may well be reasonable, it is still an assumption. He concludes:

It would seem unrealistic to view beneficial and carefully carried out clinical supervision as without therapeutic functions. Macmillan nurses brought themselves, and so their personal and professional selves, to supervision. All who occupy and influence the internal world of nurses are likely to influence the manner both in which they work and give meaning to events....the safe and effective delivery of care to patients is... inextricably linked to the personal well-being of nurses
(Jones 2000 p27).

A large evaluative study of Clinical Supervision, involving 201 nurses within an English community and mental health NHS Trust was undertaken by Bowles and

Young (1999). Using Proctor's three function interactive model (Proctor 1987), the study aimed to:

assess and compare reported benefits in each of the three functions of accountability, skill development and support in order to examine the effects of contract use, length of experience of clinical supervision and length of service as a registered nurse.... by using non-parametric statistical analysis (Bowles and Young 1999 p958).

The inevitable consequence of this kind of statistical analysis is that the authors are only able to make some very small claims, despite their relatively large study. They conclude that the nurses' reporting of clear benefits from clinical supervision in each of the three functions validates the three function model and "demonstrates that clinical supervision is used to critically examine and change nursing practice" (Bowles and Young 1999 p958). Whilst there is some concern that the 21 statements deriving from their initial stage of semi-structure interviews to derive 'reported benefits' of clinical supervision is somewhat contrived (can it really be that contributors unwittingly generated exactly seven statements per function of Proctor's model?), their findings do give some support for the usefulness of Proctor's model for providing comprehensive and well-balanced supervision:

this supports Proctor's three function interactive model and challenges the common-place notion of clinical supervision as being primarily a mechanism for simply off loading occupational stress. (Bowles and Young 1999 p962).

Interestingly, the authors also found that the length of experience of supervision is positively correlated with reported benefits, though length of service indicated fewer reported benefits in the restorative and formative dimensions, than in the normative dimension. The authors suggest that this indicates that "clinical supervision is likely to meet different needs for nurses at different points in their careers". Their claim that "clinical supervision relationships reflected each of the three functions with no single function dominating the other two" (Bowles and Young 1999 p963) must be accepted with caution, for the reason given above in respect of doubts over weighting of the statements. Nonetheless, their results do seem to indicate willingness among

participants to examine and change practice. “This supports suggestions that clinical supervision has a role within quality management and clinical governance strategies of the NHS” (Bowles and Young 1999 p963). Though once again, despite claims to the contrary, this, too, is based on perception or reported benefits and it is possible that changes were also due to participants simply becoming more comfortable with the process.

A subsequent local evaluation of a clinical supervision scheme for practice nurses was undertaken by Cheater and Hale (2001). Their findings indicate that, twelve months after the introduction of the scheme, it had received only an 18% take-up, and that 12% of practice nurses were unaware of the existence of the scheme. Reported benefits of involvement included: professional development tailored to individual learning needs and regular opportunities to share work-related problems with peers. The authors suggest that the low level of take-up and awareness of the scheme may be due to misconceptions about the purpose of supervision. This is a recurring theme in the nursing literature, where supervision remains discretionary, though recommended, as suggested in the previous section on professional identity on page 76.

An attempt to move beyond *perceptions* of ‘good’ supervision to say something more *observable* has been made by Sloan and Watson (2001b), who argue for a “systematic observation of interactions during clinical supervision as being “fundamental to an investigation that proposes to uncover aspects of the supervisory process.” They use this point to justify the need for a

greater focus on the interactions during supervision, examining what happens in supervision, what supervisors and supervisees actually do, what changes in the supervisee’s practice are discussed and what changes, if any, occur in patient outcomes

(Sloan and Watson 2001b p665).

Their approach was to record actual supervision sessions taking a longitudinal approach and to use multiple sources to provide data about the supervisory experience. They describe this approach as 'illuminative evaluation' (Parlett and Hamilton 1972), a method which explores both the 'performance' and the 'applause'. Focusing on the programme as a whole, in its natural context:

it is essentially an exploratory process and is particularly appropriate when evaluation purposes require exploration that leads to description, understanding and decisions to effect improvements rather than measurement and prediction.

(Sloan and Watson 2001b p666).

However, their study focused on the feasibility of their framework for evaluating supervision, and did not itself provide such an evaluation.

Hyrkäs (2005) cautions against overemphasising the findings from many evaluation studies, suggesting that most of them are undertaken at a very early stage following the implementation of a supervision programme (see Teasdale, Brocklehurst and Thom 2001, for example) and so may include "several unestablished factors influencing the evaluation findings" (Hyrkas 2005). This assertion is unsubstantiated in Hyrkäs' article, but the reliance of these studies on evidence from perceptions is an ongoing concern.

It is clear that a very large proportion of the evaluation literature derives from within the discipline of nursing. Whether this relates to the recognised obstacles in implementation and commitment to the practice of clinical supervision in nursing, and therefore a more pressing need for evaluation studies, is arguable. Evaluation studies that do exist in counselling and clinical psychology have tended to be American where the focus is on the supervision of trainees, rather than qualified practitioners (Holloway and Neufeldt 1995; Worthen and McNeill 1996; Herbert and Trusty 2006). This critical distinction is too rarely identified by those wishing to draw

conclusions from evaluation studies (see context and rigour section above on page 45).

One UK-based review of counsellor/therapy-related studies of clinical supervision, looking at the impact of supervision on therapists, practice and clients has been undertaken in the UK by Wheeler and Richards (2007). This provides the first attempt at a systematic review of the impact of supervision on therapy within counselling. The authors' search strategy and criteria identified 18 studies that are then listed and charted. The authors conclude that supervision:

does seem to offer opportunities for supervisees to improve practice and gain confidence, which raises the likelihood that client outcome is improved as a result of supervision. However, the link to improved outcome for clients is tentative and no studies in this review offer substantial evidence to support improvement in client outcomes. Furthermore, the majority of studies examined impacts over relatively short periods of time; the longer term impact of supervision is unknown

(Wheeler and Richards 2007 p63).

Whilst there are problems with the inclusion and exclusion criteria used in this review, as I have argued above, it does identify a regrettable lack of longitudinal evaluative studies.

The efficacy of supervision

As noted above, only a few studies have attempted to assess the benefit of supervision to the client/patient. Mearns (1995) notes that supervision itself is often the 'tale of the missing client'. Vallance (2004) has endeavoured to bridge this gap with her exploration into counsellor perceptions of the impact of supervision on clients but being only a small-scale study and based again on supervisee perceptions, conclusions can only be tentative. Her study indicated that

supervision impacts client work both helpfully and unhelpfully. Areas that emerged as having the most direct impact on clients were: exploration of client-counsellor dynamics and raising counsellor self awareness,

professional development, emotional support and, unsurprisingly, the quality of the supervisory relationship.

(Vallance 2004 p559).

An early overview of clinical supervision in nursing, exploring the state of theory, concepts and research through a search of the literature through electronic databases was conducted by Hyrkäs and colleagues (Hyrkas, Koivula and Paunonen 1999). They chose 11 articles (out of 17 identified) on effectiveness to examine in detail and concluded that these studies failed to show actual effects of clinical supervision reliably and convincingly. They concluded that research into supervisory effectiveness is still in its infancy, a conclusion supported recently by Townend (2008). He cites a number of authors (Ellis, Ladany and Krengel 1996; Milne and James 2000; Grant and Townend 2007) to support this argument concluding that “the evidence base regarding the outcomes [of clinical supervision] for clients and patients is lacking” (Townend 2008 p329). A more recent, and very tentative, study by Bradshaw and colleagues (2007), suggests that “workplace clinical supervision may offer additional benefits to nurses attending psychosocial intervention courses.” But they go on to recognise that “further research adopting more robust designs is required to support these tentative findings” (Bradshaw, Butterworth and Mairs 2007 p4). However, as I have argued in the section on rigour in the literature review on page 47, there are concerns about the criteria used to define what constitutes a ‘robust design’.

Summary of current research concerns

Tsui’s framework has provided the opportunity to scope the concerns of researchers into clinical supervision in healthcare professions. These include:

- The widespread acceptance of the functions of clinical supervision and its applicability within diverse professions and contexts, both national and

international. Reflective practice is now also widely accepted as an integral function of clinical supervision. (Tsui concern no. 1)

- Implementation issues and the difficulties in providing the kind of evidence which current healthcare practice seems to require in order to justify the provision of time and resources needed for clinical supervision to be fully implemented and maintained. This is of specific concern in the UK literature (Tsui concern no. 2)
- some emerging literature on exploring alternative formats for supervision including peer, group, multi-professional and online formats. Although these are strongly advocated by the authors of the research, it appears none of these have been widely adopted in place of the more traditional one-to-one format (Tsui concern no. 3)
- A limited number of studies focus on theoretical approaches to supervision, including those related to therapeutic traditions. It appears that cognitive behavioural therapy has become the approach most often favoured as being appropriate for an evidence-based approach to clinical supervision (Tsui concern no. 3)
- The importance of the supervisory relationship is, without doubt, the most frequently cited factor in those qualitative studies that seek perspectives on what makes for good supervision but there is concern that much of this is based on perception and self-report evidence *only*. Outcome evidence to support the importance of the quality of the supervisory relationship over other factors in supervision has not been forthcoming (Tsui concern no. 4)

- A number of threads of specific interest to certain groups of researchers have been pursued including the role of supervision for developing leaders and preventing burnout (Tsui concern no. 5 and 6).
- There is an acknowledged lack of research into the prevalence, content and quality of training and preparation for supervisors and despite Tsui's assertion to the contrary, gender issues do not appear to be a specific concern to researchers of clinical supervision, at least in health. (Tsui concern no. 7 and 8)

Additional aspects that are of concern to researchers of clinical supervision identified in this review include:

- The role of supervision in developing a professional identity and the impact of cultural and professional constraints (additional concern no. 9)
- whilst there have been some attempts to evaluate the process and impact of clinical supervision, findings are extremely limited and little or nothing has been confidently reported about the effect of supervision on the patient/client/service-user. Of the evaluations that do exist, most are reliant on perceptions and self-report and there is a lack of longitudinal evaluative research (additional concern no. 10)

This section of the literature review has outlined those areas of concern to researchers into supervision. What is clear is that much investigation has been undertaken into specific elements of the practice of supervision, with a number of them apparently under-researched. Emerging from the review are some insights around the content knowledge held within the disciplines about supervision and, thereby, what can, and cannot, be said about it. Taken together, this body of

research evidence and literature represents the *sites* and content of the *knowledge* about supervision (*the discipline*). It reveals who the experts are (the *authors*) and provides insights into their concerns (the *commentary*) (Danaher, Schirato and Webb 2000). As the discursive frame is constructed in chapter six, it will begin to become evident as to which *authors*, which *commentaries* and which *disciplines* draw from each of the dominant discourses.

Review section three: discourse of the professions

This thesis focuses on three professions whose practitioners work directly with mental health patients/clients/service users and, as such, have a number of activities, functions and goals in common. They were chosen because they also share a commitment to the practice of (clinical) supervision. This final section of the literature review explores the discourses about supervision found within each of these three professions. The intention is to identify those discourse which emerge as dominant, that shape whole patterns of thinking about the nature, practice and usefulness of supervision, what Foucault refers to as 'regimes of truth' (Foucault 1980). It comprises four subsections starting with the professional context within which all three professions operate. This is followed by an exploration of the contexts of each of the three professions individually: mental health nursing, counselling and, finally, clinical psychology. In this way, the contemporary discourses can begin to be identified and constructed into the discursive frame of the next chapter.

1. The professional context

Literature produced by the numerous professional, statutory and regulatory bodies representing these three professions provides a great deal of insight into the way the professions each position themselves with their contingent responsibilities towards society. Each of the professions has experienced a complex, inconsistent and often contradictory journey in its engagement with wider governmental and social agendas.

These changing agendas have at times driven change and at other times apparently resisted it.

This sub-section explores the roots and histories of the professions through an analysis of the discourses around:

- 1a. the professional and regulatory bodies
- 1b. approaches to regulation
- 1c. the changing nature of the professions themselves
- 1d. the emergence of managerialism in the delivery of healthcare

1a. Professional and regulatory bodies

Each of the identified professions is represented by at least one professional body, but their remits, size and history are contrasting. For nursing, the Nursing and Midwifery Council (NMC) is its regulatory body and the Royal College of Nursing (RCN) its professional body. To date, Clinical Psychologists are represented by one body: the Division of Clinical Psychology (DCP), one of seven domains within the British Psychological Society (BPS). The DCP was formed in [about] 1966 and by 2010 represented approximately 9000 qualified clinical psychologists in the UK, making it the largest Division of the BPS. The BPS has charitable status and until 2009 maintained a voluntary register of practitioners. In 2009, this register was taken over by the Health Professions Council (HPC) and the registration and regulation of the psychology profession became statutory (see below). The BPS itself was formed in 1901 and has more than 45,000 members. Its website explains:

Through its Royal Charter, the Society is charged with overseeing psychology and psychologists. It has responsibility for the development, promotion and application of pure and applied psychology for the public good.

BPC website: http://www.bps.org.uk/the-society/about-psychology-and-the-society/about-psychology-and-the-society_home.cfm accessed 6th April 2008)

The British Association of Counselling and Psychotherapy (BACP) was formed in 1977 (as the British Association for Counselling: BAC). It is the largest body representing the counselling profession though by no means the only one. There are at least six others including the United Kingdom Council for Psychotherapy (UKCP): the Independent Practitioners Network (IPN), the Association of Christian Counsellors (ACC) and others. In the same way as the DCP, the BACP is also a professional body maintaining a voluntary register of practitioners. It, too, has charitable status, though with no Royal Charter. These variations in structure between the professions provide some indication of the way in which they are each perceived in the wider professional context. To have regulatory powers affords the organisation a statutory role. Failing that, royal status confers on it some high status recognition. To have neither statutory, nor 'royal' recognition would suggest a lower-status for the organisation within the wider context of professional, statutory and regulatory bodies (PSRBs).

1b. Approaches to regulation

The way in which each of the professions documents their experiences in respect to regulation is of particular interest, not least because they reveal much about how the professions see their safeguarding role, which has implications for supervision (see chapter on the discursive frame on page 131).

The Government White Paper: Trust Assurance and Safety of 2007, which derived from the Foster Review of 2006 (DH 2006a), states:

The Government is planning to introduce statutory regulation for applied psychologists, healthcare scientists, psychotherapists and counsellors and other psychological therapists. These are the priorities for the introduction of statutory regulation, because their practice is well established and widespread in the delivery of services, and what they do carries significant

risk to patients and the public if poorly done. Further work is needed on these areas and the Government intends to continue with it.

(DH 2007b paragraph 7.2)

This statement instigated the process of bringing the regulation of the professions of clinical psychology and counselling (among others) together under the auspices of the Health Professions Council (HPC). The ensuing Health Care and Associated Professions (Miscellaneous Amendments) No 2 Order (Dec 2007) introduced the statutory regulation of practitioner psychologists through the HPC. As indicated above, this register was opened in July 2009 and is managed and run by the HPC. This represents a fundamental shift in the regulation of psychology. The Society had historically been strongly in favour of statutory regulation, as illustrated by this quote taken from the Society's website:

Proper Public Protection and Psychological Services

Under current law, anyone can claim to be a psychologist, psychotherapist or counsellor and offer their services to the public irrespective of their training or experience.

This fact may come as a surprise given the potential for harm to the mental well-being of clients, especially when the professions are compared with, for instance, doctors, lawyers and nurses, who have had statutory regulation for many years, offering the public legal safeguards from the unskilled and the unprofessional.

(http://www.bps.org.uk/the-society/statutory-regulation/stat-reg_home.cfm)

Accessed 06.04.08)

Aligning themselves with doctors, lawyers and nurses in this way, suggests an attempt to position the profession amongst high-status, longstanding and well-respected professions, particularly in terms of their specialised role in the important task of public protection. In addition, use of the word 'proper' in this context implies that to challenge the underlying assumption of the need for regulation would not only be contrary to the view of the Society but, in a much more moral and universal sense, 'improper'. However, up to the point in which the register opened, the BPS was strongly against it being held and managed by the HPC, preferring instead to establish a Psychological Professions Council, along with a number of other bodies,

including the BACP. The Society was concerned about the way in which the title of 'psychologist' would be protected under the HCP and it argued strongly against the HPC providing this protected status. The Society was overruled by central government. A presentation on the DCP website, explaining the differences between the two bodies (BPS and HPC) for members' information, states:

Because the HPC is not a professional organisation, and provides none of the benefits described above – it is not there for you, it is there to protect the public from you!

(<http://www.bps.org.uk/dcp/> accessed 22.04.10)

This statement runs contrary to the earlier one. It appears that the Society at once wants to be seen as a highly specialised profession that needs to be regulated in order to be 'proper' in its duty to protect the public and, at the same time it wants its members to see it as standing up to the regulators in their role in protecting the public from the profession. At time of writing (April 2010), it would appear that the relationship between the two organisations is still uncomfortable, though information on the main BPS website now affirms the need to work with the HPC:

Getting to where we have arrived has been a long and complex process. The Society started work on gaining statutory regulation back in the early 1980s. There have been many individuals involved, both members and staff, to whom I must extend an enormous thank you. This includes those, both members and lay people, who have been involved in our own investigatory and disciplinary processes over many years and who have helped us to achieve the standards we have. It also includes those who have contributed to training, research and applied psychology.

The Society's role now in terms of regulation is to work with the HPC to ensure that it is a success.

http://www.bps.org.uk/the-society/statutory-regulation/stat-reg_home.cfm accessed 22.04.10)

The regulation of counselling is also due to come under the Health Professions Council, though has been subject to long delays. Information on the BACP website suggests that the likely date for regulation to begin is now 2011/12

<http://www.bacp.co.uk/regulation/RegulationFAQ.php> accessed 22.04.10). Like the BPS, the BACP is in favour of the regulation of counselling in principle, but as indicated above supported the proposal for the formation of a psychological regulation council. The BACP's argument for not coming under the auspices of the HCP was that approximately 70% of practising counsellors do not work within a healthcare environment. Further concern about the emphasis on a medical model by the HPC was expressed to me in a personal communication with the head of supervision of the BACP (March 2008). A letter sent to the Chair of the HPC by the BACP in December 2007 illustrates that serious concerns exist about the direction of travel and the nature and manner of decisions being made:

(<http://www.bacp.co.uk/regulation/index.php?newsId=363&count=7&start=0&filter=&cat=&year=> accessed 06.04.08).

The Nursing and Midwifery Council (NMC), as the single statutory regulatory body for nurses and midwives, was created by the government in 2002, at the same time as the HPC. Despite the fact that its roots go back much further and, as such, has a much longer history than bodies representing the other two professions, it shares the experience of the two other professions in that nursing's journey towards regulation has also been marked by much dispute and debate. In the early part of the twentieth century, the professional body for nursing (the College of Nursing, later to become the Royal College of Nursing), gained support for a private members bill to establish a regulatory system. The Nurses Registration Acts for England/Wales, Scotland and Ireland were passed in 1919. These acts established what were to become the United Kingdom Central Council (UKCC) and the National Boards following further legislative changes in 1979.

(<http://www.nmc-uk.org/aArticle.aspx?ArticleID=1634> accessed 08.04.08)

The medical profession has a long history of self-regulation and it has traditionally been viewed with status and respect by the public and government alike. One reason why other, newer, and related health professions look for regulation and protected titles is as an aspiration towards a similar respect and status and regulation may be seen as one way to achieve this. The desire for regulation and for the 'protected titles' that regulation affords may be seen as one way to maximise the profession's status in the public mind.

In the hierarchy of regulation, the statutory right to self-regulation, as afforded to the NMC, is seen as preferable to the professional body devolving the regulatory function to another agency, in this case the Health Professions Council. In this case, the professional bodies need to carve out their own distinct purpose and function within a conglomeration of health professions, some of which may be perceived as 'pseudo' professions in the public mind. In the UK, counselling has struggled to emerge from a perception of it being one of these 'pseudo' professions and the fact that its hoped-for regulatory status has been subject to several years of delays may only serve to promote this perception. At least 14 other professions (at 2010) come under the umbrella of the Health Profession Council, including physiotherapists, occupational therapists, art therapists and hearing aid dispensers.

There is an ongoing contradiction in these professions' march towards regulation, in that by advocating and fighting for regulation, professions are, in fact, diluting an integral aspect of what has traditionally constituted a 'professional' – independence and autonomy (Grant and Townend 2007, quoting O'Neill's Reith lecture of 2002: <http://www.bbc.co.uk/radio4/reith2002/lectures.shtml> accessed 02.05.08). This perhaps reflects changing public attitudes towards the professions.

1c. The changing nature of the professions

Public and professional opinion has moved on in the course of this debate, from a position where trust alone was sufficient guarantee of fitness to practise, to one where that trust needs to be underpinned by objective assurance.

(DH 2007b paragraph 2.3)

This statement represents a fundamental shift in the perception and assumptions about what constitutes a 'professional' and as such should not be underestimated in terms of its implications. It is evident that public support for this move can be located in responses to cases such as Shipman and Allitt (Shipman Report 2005:

<http://www.the-shipman-inquiry.org.uk/reports.asp> accessed 22.04.10; (HMSO

1994). However, these headline-making cases have provided the political platform from which the notion of the autonomous professional, trusted to interpret and deliver their practice according to their expertise and professional judgement began to be irrevocably undermined. Who could argue with the call for 'society' to exercise its moral obligation to protect the vulnerable from such evil practice?

[Professions] are based on knowledge which is not generally held by or available to laymen and is gained by formal education, [they] have a distinctive organisation of the profession with some power over access to the profession or at least to the title under which it is professed, as well as a special code of conduct referring to the professional person's access to the aspects of the individuals' lives which are regarded as private. This access entitles the practitioners of the profession to the privilege of maintaining secrecy regarding their relationships with those whom they serve.

(Glazer 1974 p348)

In contrast to the major professions (medicine and law), Glazer argues that the minor professions do not carry the same independent status, but rather come under more bureaucratic authority. This is clearly evidenced by each of the three professions in this study as they have sought to attain the status of a major profession but have found themselves caught up in much tight bureaucracy and external constraint. Nonetheless, this has not deterred them from continuing to develop and implement those activities which are perceived to be integral to a profession. For example, in

addition to regulation and the protection of titles, the development of ethical codes of practice and the contingent disciplinary processes for breaches of the codes form a core activity of the professional bodies of each of the three professions:

During the 'professional' phase [when the oldest professions were becoming established] classic professions such as medicine and law were marked by their particular use of ethics codes. Codes acted as a means of self-assertion for the professions, and served as both an expression of identity and as a means of self-regulation....ethical codes functioned as levers in strivings for professional status....

(Meulenbergs, Verpeet, Schotsmans and Gastmans 2004 p332)

However, as newer, 'minor' professions, these codes may not afford them the status they hope to achieve. Meulenbergs et al go on to propose that there now exists a 'post-professional' phase, characterised by "a decline in the monopoly of traditional professions over a specialised body of knowledge":

a different mode of institutionalisation operates and it is no longer the professional group that is responsible for catching the individual professional in a web of duties and responsibilities... the profession itself is being institutionalised...ethical codes are, thus becoming mechanisms of control rather than instruments for the promotion of ethics [in nursing]

(Meulenbergs, Verpeet, Schotsmans and Gastmans 2004 p4)

1d. The emergence of managerialism in the delivery of healthcare

...a general feature of modernity, the rise of the organisation. What distinguishes modern organisations is not so much their size, or their bureaucratic character, as the concentrated reflexive monitoring they both permit and entail The modern world is a 'runaway world' [in terms of speed and depth of change]

(Giddens 1990)

This 'runaway world' is acutely in evidence in relation to changes in the context of health. The Socialist Health Association highlights the unprecedented amount and speed of change. The association has produced a timeline tracing the many and varied reforms that have been implemented within the Health Service right through from 1855 to the present day. It reports that 2007 was "the first year since 1993 when major reform was not proposed or implemented - though it was the year when many earlier reforms began to bite" (<http://www.sochealth.co.uk/news/NHSreform.htm>)

[.accessed 01.02.08](#)). At the time of writing (July 2010), further major reforms have been announced by the new coalition government in respect of devolving decision-making to general practitioners. At this point it is not clear how this will be managed or achieved.

The Thatcher government of the 1980s is credited with introducing the 'business model' into the National Health Service (NHS) by creating the internal market, and in so doing, introducing the discourse of business into this bastion of the welfare state (Gordon and Wimpenny 1996). Initially, this brought with it an explicit emphasis on 'cost effectiveness', 'choice' and 'quality assurance' as exemplified in the then Health Secretary, Virginia Bottomley's foreword to the 1993 Department of Health (DH) policy document 'Vision for the Future' (DH 1993). However, subsequent DH statements shifted away from this overt cost effective/efficiency language, though still emphasising the 'quality' agenda, as illustrated, for example, in the government white paper: 'The new NHS – modern dependable' (DH 1997) which first introduced the clinical governance agenda. An emphasis on quality and standards can also be found in the Chief Nursing Officer (CNO)'s review of mental health nursing with its focus on "modernising and improving the quality of care for service users" (DH 2006d p3). An article in the Nursing Standard (a professional journal published by the RCN) in 1999 discusses the concept of quality in the new NHS. This article locates the drive towards the 'quality' agenda in the NHS as deriving from cases such as Allitt, (HMSO 1994), which

caused widespread public and political concern and heightened general awareness of the potential for harm when health services go awry. They have also engendered a period of deep reflection and critical analysis among the health professional, and growing support for major changes in the way quality and performance are managed

(RCN 1999)

The significant shift in emphasis of which this article is an example is the way in which the introduction of the government's marketisation agenda was facilitated

through the discourse of professional reflection and pride, simply by the shared use of the word 'quality', without disaggregating the different assumptions underpinning that word. Most significantly, this article directly connects the development of clinical governance through the local delivery of clinical supervision and in so doing, associating notions of 'quality' with marketing and auditing processes with the practice of supervision.

This focus on a need to assure quality of service is recognised by Clarke and Newman as part of an encroaching managerialism in the public sector:

Many areas of professional service are characterised by a rather different strategy: that of co-option. This refers to managerial attempts to colonise the terrain of professional discourse, constructing articulations between professional concerns and languages and those of management. Thus, corporate missions and strategies have increasingly moved from the bare pursuit of efficiency, [from the business model], to a concern with standards of service, the pursuit of excellence and the achievement of continuous improvement.

(Clarke and Newman 1997 p76)

Through this process of co-option, the onus for delivering a quality service can be framed as part of a professional responsibility and thereby devolving responsibility from a central government concern to one which is espoused by practitioners as part of their professional duty. By conflating the idea of 'quality' (from the managerial discourse) with the idea of 'professionalism' (from the professional discourse), accountability for the delivery of 'quality' can be devolved to the local, even individual level, with pressure on the individual practitioner to assert their professionalism by accepting the responsibility and to engage in a process of self-monitoring. Inevitably, such self-subjugation requires an extensive network of regulation and administration, key features of 'modernity' (Giddens 1990), in order to achieve the efficiency and effectiveness required by the management of that society. Modern society looks to the individual to monitor him/herself to enable the effective mass observation of a large body of practitioners. In this system, regulatory, professional, statutory or other

agencies need to be seen to be actively observing to encourage that self-monitoring (you never know who and when they may be watching). A professional is deemed to be such by the very fact that they monitor and regulate their own practice. These practices are reminiscent of Foucault's thinking on the nature and purpose of the Panopticon (Foucault 1977) and will be discussed further in the discussion chapter.

2. The mental health nursing context

A key policy document in mental health nursing, the Chief Nursing Officer's review, *From Values to Action* (DH 2006d) repeatedly emphasises that all mental health nurses should make use of regular clinical supervision, (pp 13 and 18 for example). The term 'clinical supervision' is mentioned at least 12 times in the document and suggests a commitment to its value and practice. This section will analyse a number of prevalent discourses that can be found in this and other nursing documentation in order to identify the dominant discourses which will comprise the discursive frame.

The profession of nursing in general and mental health nursing in particular has a much longer history than either of the other professions, with literature dating back to the nineteenth century and arguably a much larger profile in the public mind. There is, therefore, significantly more professional and policy literature available for analysis than there is for both counselling and clinical psychology. Within this body of literature, a number of recurring discourses can be identified, each in its own way impacting, to a greater or lesser degree, on the discourses of supervision. These include:

- 2a. The changing nature of care
- 2b. The changing profile of the patient
- 2c New ways of working
- 2d Recruitment and retention
- 2e Managing risk

2f Problems of implementation

This section will explore each of these in turn before looking at a number of related issues that are pertinent to supervision in particular.

2a The changing nature of care

Nature alone cures... And what nursing has to do... is to put the patient in the best condition for nature to act upon him.

(Nightingale 1859)

Nursing is...the use of clinical judgement in the provision of care to enable people to improve, maintain or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death.

(RCN 2003 p3)

Throughout its history, from its origins in the writing of Florence Nightingale to the twenty-first century Royal College of Nursing (RCN), nursing has sought to establish its unique and distinctive contribution, and this has always been based around notions of 'care', firstly as an assistant to the doctor and latterly as a distinct and parallel discipline:

Nursing has moved a long way from the medical 'assistant' of the powerful doctor and, as such, is finding its own discourse: 'the demedicalisation of nursing'....Nursing has moved towards the social sciences and looked for explanations from sociology, psychology and theories in education....new ways of organising and presenting nursing care have been established (the nursing process) ... moving from a more task-oriented work towards a more person-centred approach with individualised planning as a means to action... to form a relationship with their patients

(Butterworth and Faugier 1998 pp4-5)

In this extract, Butterworth and Faugier recognise the nursing profession's progress towards identifying itself as a distinct 'discipline', furthered by the introduction of the nursing degree in 2000, with the notion of 'care' at its heart. Traynor has provided an analysis of the history of nursing discourse which includes some important comments about nursing attitudes towards 'care'. He highlights three stages in the evolution of concepts of caring: caring as *duty* (from Nightingale), caring as a

therapeutic relationship (1970s/80s), to *caring as an ethical position* (from Benner). (Traynor 1996). Chiovitti describes care as 'protective empowering' derived from her grounded theory study of psychiatric nurses, the aim being to guide "discussions about organisational values of person-centred care within a collaborative multidisciplinary context" (Chiovitti 2008 p203).

Johansson, Holm et al (2006) undertook focus group interviews with supervisors in nursing to understand how the value of caring was expressed through the practice of supervision:

the assumption behind this study is that nursing supervision encompasses experienced knowledge of the value of caring, upon which it is necessary to reflect... the most fundamental meaning of the value of caring in nursing supervision is the genuine encounter where one human being encounters another

(Johansson, Holm, Lindqvist and Severinsson 2006 pp645-6)

Whilst this discourse of care is seen in the profession to be what separates it from the diagnosis/treatment/cure discourses of the medical model, the term itself is not straightforward. Within professional discourse there is some concern that changing priorities in nursing risk losing that essential 'art' of caring. For example, Corbin (2008).comments in her guest editorial to the International Journal of Nursing

Studies:

It seems that caring is an elusive term, one that has different meanings in different contexts, therefore one hard to define

(Corbin 2008 p163).

Furthermore, in the same way as the term 'quality' has been transplanted from the context of professional practice into the discourse of quality and clinical governance (see above), so the term 'care' is at risk of a similar transplantation. This is epitomised in the Department of Health's *Essence of Care* initiative, which appeals to this distinctive value held within the profession but is couched within the discourse of clinical governance:

'The Essence of Care' has been designed to support the measures to improve quality, set out in 'A First Class Service', and will contribute to the introduction of clinical governance at local level. The benchmarking process outlined in 'The Essence of Care' helps practitioners to take a structured approach to sharing and comparing practice, enabling them to identify the best and to develop action plans to remedy poor practice.

(DH website:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005475 accessed 22.04.10)

In this way, the dual concepts of 'care' and 'standards' are explicitly linked together.

The link has been further reinforced in the Chief Nursing Officer's (CNO) 2006 review of mental health nursing, *From Values to Action* referred to above (DH 2006d). The main aim of the document was to address the question, 'how can mental health nursing best contribute to the care of service users in the future?' reinforcing the ongoing concern of placing 'care' at the centre of nursing practice, this time specifically in mental health nursing. However, this document also emphasises 'standards': "modernising and improving the quality of care for service users" (DH 2006d p3) and refers to another Department of Health publication, *Standards for Better Health* (DH 2004a).

2b The changing profile of the patient: from patient to person

Changing models of care go hand-in-hand with changing attitudes towards the role of service users themselves:

A paternalistic model of care creates tension related to the primacy of autonomy in care giving

(Harnett and Greaney 2008:3).

Butterworth and Faugier (1998) identify a move towards a 'person-centred' approach to care and this has continued to be an area of significant growth since the time of their writing, where the 'service user' has become increasingly central to all care planning and delivery. This is illustrated by the evolving terminology used to describe the recipient of care. The Chief Nursing Officer's Review of Mental Health Nursing, uses the term 'service user', which is the term normally preferred by other social care

disciplines such as social work. A service user can be seen as an “active participant in their own recovery rather than a passive recipient of expert care” (Harnett and Greaney 2008 p3). In the NMC’s 2004 Code of Professional Conduct, the terminology used is ‘patient or client’ but in the revised Code, published in 2008, the ‘patient or client’ has become ‘the people in your care’. (NMC 2008), illustrating just how quickly the terminology is changing. There is a large amount of literature around the increasingly central focus on the service user, and is matched by a growing number of service-user groups, managed and run by service users themselves and which play an increasingly active role in shaping services at multiple levels. This drive to place the user at the centre of care has led to new developments in models of working in mental health, most notably the *Recovery* model (NIMHE 2005; Bonney and Stickley 2008).

However, the language of user-centredness has itself been coupled with the language of standards and efficiency:

the heart of the policy changes are concerned with placing users of the service and their carers at the centre of the service provision coupled with the demand that the service is of high quality and cost effective

(DH 1993 Foreword)

2c New ways of working

New ways of working is an approach that seeks to encourage people working in mental health to change traditional ways of working and take on new roles in order to provide a better service to people with mental health problems

(DH 2006d p45)

The New Ways of Working strategy was launched in 2007, but to date (2010) it is unclear exactly what its remit or outcomes have been. This may be partly due to the fact that NIMHE, the organisation tasked with delivering the strategy was incorporated into the new National Mental Health Development Unit in 2009 which may have shifted the anticipated emphasis of the strategy. Perhaps the most visible outcome to date is the introduction of the new Approved Mental Health Practitioner

(AMHP), replacing the former Approved Social Worker, and thus enabling a wider range of professionals, including mental health nurses, to undertake statutory assessment roles in mental health. This development indicates a shift towards the emergence of more generic mental health practitioners and is not uncontested.

2d Recruitment and retention

It is vital to put the recruitment and retention of MHNs at the forefront of Trust human resources activity but within the context of the Integrated Service Improvement Programme, the development of New Ways of Working and the introduction of New Roles. While these might represent a challenge, they also provide an opportunity to help focus on the role of mental health nursing and how this interacts with other roles, and to provide a career framework

(Summary to the Chief Nursing Officer's Review (DH 2006d p8)

An investigation into stress, recruitment and retention comprised one of only three literature reviews commissioned by the CNO in compiling her review (the other two being efficacy of mental health nursing interventions and service users' and carers' views of mental health nursing). There is a growing body of research evidence to suggest that stress and burnout have a substantial impact on both retention and work satisfaction of mental health nurses. This is often cited as one of the justifications for a policy of clinical supervision. For example, in the Recruitment and Retention of Mental Health Nurses Good Practice Guide (2006) associated with the above publication, clinical supervision is mentioned only once, and that in relation to a means of enhancing retention:

Improve nursing skills and knowledge....Ensure staff have clinical supervision and protocols in place

(DH 2006b p16)

However, the need to implement effective retention strategies is not new. In 1999, the NHS published the National Service Framework for Mental Health: modern standards and service models (NHS 1999). This framework recommended the implementation of local workforce strategies including a retention strategy comprising

measures to tackle stress, to improve working conditions, and provide ‘proper’ clinical supervision and appraisal; to be delivered by 2001.

to identify priorities for action to support staff in managing stress and ensure that local and, if appropriate, national action is taken including mentorship, coaching and appropriate clinical supervision

(NHS 1999 p111)

2e Managing risk

The localisation of policy delivery is evidently something that the central authorities are very keen to reinforce, as highlighted in the section above on the emergence of managerialism and can be seen as means by which risk is managed and devolved. The term ‘local’ is used 40 times in the CNO’s review within a 78 page document, averaging one mention every two pages. Local Trusts are assigned the responsibility for interpreting, integrating and implementing all the varying guidance and provide clear and attractive career frameworks.

The *Recruitment and Retention of Mental Health Nurses – Good Practice Guide*, referred to above, continues this emphasis: “Implementation is at local discretion and should be based on local need.” (DH 2006b p4). Here, as in other guidance in relation to the provision of clinical supervision, the promotion of *local* policies and procedures is recommended. It is of clear benefit to the organisation if responsibility for delivering strategy can be devolved to the local level as an effective form of ‘localised managerialism’. This has a double benefit from the organisation’s perspective: reducing the responsibility on the organisation to be accountable for the service provided, while at the same time appearing to reinforce the concept of professional autonomy. The NMC has certainly embraced with enthusiasm the notion that nurses are, by virtue of their registration, personally accountable for their actions (NMC 2008)., a view supported by the RCN in its *Defining Nursing* document of 2003 (RCN 2003).

In addition, the only identified Department of Health publication exclusively concerned with supervision: *Clinical Supervision in Prison Nursing – getting started* opens with the statement “Clinical Supervision has been produced as a method of ensuring safe and accountable practice in nursing” (DH 2002 p1). Further:

Clinical Supervision is a term to describe a formal process of professional support and learning which enables practitioners to develop knowledge and competence, assume responsibility for their practice and enhance consumer protection and safety of care in complex situations

(DH 2002 p1)

An explicit function of the NMC is to ‘protect the public’ and this infuses all its guidance. For example, this phrase is included in the introduction to all its advice sheets, including the one on clinical supervision (NMC 2006).

Within the NMC Code (NMC 2008) an emphasis is placed on personal accountability and minimising risk. However, no reference is made to clinical supervision being a means by which to manage these two responsibilities. It is clear from the number of times the phrase ‘you must’ is used by the NMC in this *Code* (increasing from 45 times in a 15 page document in the 2004 version to 64 times in 7 pages in the 2008 version) that the organisation does not shrink from making aspects of practice mandatory, so why it shrinks from making the connection between these requirements and the practice of supervision is not clear. In their advice sheet on clinical supervision it only goes so far as to say that registrants should ‘have access’ to it. This could be one reason why the nursing profession seems reluctant to embrace the practice of clinical supervision, a concern highlighted in the literature review on page 76.

2f Problems of implementation

The analysis above of the wider professional literature which impacts on the discourse of supervision would suggest a number of possible reasons for this including:

- A lack of shared understanding
- A lack of consensus on supervision models
- Some resistance to the practice, particularly within the nursing profession

Lack of shared understanding

Walsh et al (2003) identify ambiguities in the literature both with the term and with regards to how supervision should be conducted. Furthermore, Fowler's (1996) review of the literature on clinical supervision recognised the lack of consistency in the use of terminology around the practice of clinical supervision in nursing. He identified a number of terms being used almost interchangeably at that time including preceptor, mentor and supervisor. One reason for the perpetuation of mixed terminology could be that perhaps *the* most influential book on supervision in nursing: Clinical Supervision and Mentorship in Nursing (Butterworth and Faugier 1998) combines the terms 'mentorship' and 'supervision' as one concept in the introduction. Whilst they later attempt to distinguish between the terms 'mentor', 'assessor', 'clinical supervisor' and 'preceptor', the opening page of the opening chapter states:

the contributors to this book use the term 'clinical supervision' to embrace a range of strategies in nursing which include preceptorship, mentorship, supervision of qualified practice, peer review and the maintenance of identified professional standards, which gives some indication as to the breadth of subject definition"

(Butterworth and Faugier 1998 p3)

This statement would appear to further obscure any distinctions between clinical supervision and other strategies. Hyrkäs, Koivula and Paunonen (1999).suggest that whilst in the UK clinical supervision can be used as a synonym for preceptorship

and/or mentoring, closely allying the activity to initial education, in Scandinavia clinical supervision is only provide *after* qualification. This may be one reason why the practices of 'mentorship' and 'preceptorship' are both now embedded in mandatory practice within NMC guidance (NMC 2007) whereas clinical supervision has only ever achieved recommended status within the nursing documentation. Despite the introduction of clinical governance into the National Health Service and its apparent endorsement of clinical supervision as a means by which quality could be delivered, it still remains an option. Butterworth and Faugier (1998) argue that clinical supervision is needed to "protect patients from nurses and nurses from themselves" and yet, for some reason, it has not been made mandatory, in stark contrast to the professions of clinical psychology and counselling.

Lack of consensus on supervision models

Guidance documents (RCN 2002 for example) tend to indicate that there is no one model of clinical supervision. The RCN guidance, for example suggests that readers should follow up the recommended sources and come to their own decision about what would work best at the local level. This view is supported by the findings of Jones' review of the literature.

This study suggests that a single approach to clinical supervision could be unhelpful to nursing

(Jones 2006 p577)

Nurses' own resistance to the practice of supervision

An article in the Nursing Times in January 2005 considered barriers to the lack of progress in embedding clinical supervision into nursing (NT 2005). These included: lack of definition, methodologically flawed research into job stress, that supervision was seen as organisational surveillance, self-indulgence and management resistance, among others.

The resistance shown by nursing towards clinical supervision remains perplexing

(Jones 2006 p577)

A number of reasons have been given for nurses' own resistance to engaging in clinical supervision, even where it is available. It may be that practised nurses often find it easier to demonstrate their knowledge and expertise through tasks, than to explain in words (Benner 1984) or that nurses are reluctant to explore the affective dimensions of their work, preferring instead to take a 'tea break/tear break' as a way of letting colleagues share stressful clinical experiences (Butterworth and Faugier 1998 p9). It is also possible that reflection is a difficult process that does not suit all nurses or that self-observation can challenge personal and professional ideals, resulting in feelings of distress and perhaps shame. Jones reports that clinical supervision can cause discomfort and perhaps anxiety where there already exists a high emotional cost of 'caring' (Menzies 1960):

the clinical nurse [is] faced with dealing not simply with the patient's psychology, but also her own

(Butterworth and Faugier 1998 p4)

It could be argued that the decreasing reference to clinical supervision in official policy guidance is merely reflecting and, perhaps, deflecting the fact that it has failed to become embedded in nursing practice to the level that was originally anticipated. Grant (2003) for example, suggests that NHS bureaucracy has consistently failed to heed the messages about failure of implementation, preferring what Goffman described as "face saving and impression management" (Grant 2003 p23).

3. The counselling context

The practice of counselling and psychotherapy in the UK is, in general, a much more independent practice than that of nursing or clinical psychology. Whilst there are counsellors working within the NHS, there is a far larger number working in voluntary or private practice. The professional bodies, therefore, could be seen to be less

constrained by wider contextual factors and policy changes than the other professions, while at the same time it could also be argued they carry a greater responsibility for the wellbeing of both the clients and the practitioners for the same reason.

The BACP has produced a supervision strategy and action plan

http://www.bacp.co.uk/supervision/strategy_action_plan.php (accessed 23.04.10).

The definition of supervision provided in this document is:

For the purposes of this document then, supervision is defined as the reflexive exploration and development of helping practice, in a supportive yet challenging context, involving individuals in the role(s) of supervisee and supervisor. BACP acknowledges the need to research this term and its associated role activities

However, the strategy is dated 2005 – 2008 and the Action Plan 2005 – 2006 (two years and four years out-of-date respectively). Whilst the website indicates that supervision pages are to be added shortly, this is currently the only available document on supervision on the BACP website, suggesting that, at least for the time being supervision is not a high priority for the organisation, though they are running a series of seminars, funded by the European Social Research Council (ESRC) in 2011.

The BACP is the largest of a number of professional bodies representing various counsellor groupings, many providing their own regulation and monitoring processes. Guidance on the nature and practice of supervision provided by the BACP includes two information sheets.

S1: 'How much supervision should you have?' (Mearns 2004)

S2: 'What is supervision?' (BACP 2004). These include some key assumptions about the nature and practice of supervision:

1. That supervision in counselling is not identified as 'clinical'; suggesting, perhaps that there is not a traditional need in counselling to distinguish it from managerial supervision, or to align itself to a medical model

2. That supervision is a means of quality assurance:

supervision is a process to maintain adequate standards of counselling and a method of consultancy to widen the horizons of an experienced practitioner" (p1). From advice sheet on clinical governance (DG 9 2003) "The Ethical Framework requires all members of BACP to be in regular supervision in order to offer some quality control of practice

(S2:3)

3. That counsellors will choose their supervisors:

in choosing a supervisor, counsellors need to....

(S2:1)

4. Almost the opening statement seeks to establish a rejection of notions of surveillance:

Counselling supervision is not about 'policing', where the emphasis is solely on 'checking up' on you. Instead the aim is to develop a relationship in which your supervisor is regarded as a trusted colleague who can help you to reflect on all dimensions of your practice and, through that process, to develop your counselling role

(Mearns 2004 p1)

5. Quantity does not reflect quality.

[The nature of supervision] while maintaining its developmental function, will vary considerably across the different counselling approaches.

(S1:1)

In other words, the primary emphasis of supervision is on development and while recommendations will be made about quantity, this will not be a sufficient measure to assess the quality of the supervision provided.

6. The maintenance of 'health' is seen as the purpose of the supervision, according to the opening sentence. The maintenance of 'wellbeing' is referred to on the opening page of S1 as well as the assertion that "employers have a responsibility to ensure that their counsellors have adequate counselling supervision". No reference is made here to how this responsibility may be communicated, maintained or enforced.

7. In contrast to the large number of directive phrases included in NMC guidance, as noted above, the phrase 'you must' appears 64 times in the seven page *Code of 2008* (NMC 2008), the discourse in this counselling leaflet appears at first sight to be much more flexible and responsive to individual circumstances. For example:

you, and counselling in general, will be better served by coming to an understanding of the issues involved in determining the amount of supervision necessary..... any initial decision is open to regular review to take into account changing circumstances and inaccuracies in earlier judgements (S1:1).

However, on closer reading, other words and phrases can be discerned which present a slightly different message: "It is essential that...", "It is also important that...", "In choosing a supervisor, counsellors need to..." (S2 p1) "private practitioners must arrange their own supervision" (S2 p1). In information sheet S2 (a 1300-word document) there are 14 occurrences of the term 'should', three of the term 'ensure', four of the term 'must' and five of the term 'essential'. Whilst these terms are often found within sentences that appear to be promoting a flexible approach to supervision, there is clearly a substantial pressure to conform.

In the most widely used guidance document provided for the practice of counselling and psychotherapy in the UK, the British Association for Counselling and Psychotherapy's *Ethical Framework for Good Practice in Counselling and Psychotherapy* (BACP 2007 (first published 2002)), there are four references to supervision, twice in the 'Values' section:

- a. under 'Beneficence: a commitment to promoting the client's well-being:

There is an obligation to use regular and on-going supervision to enhance the quality of the services provided and to commit to updating practice by continuing professional development

(BACP 2007 p3)

- b. under 'Self-respect': fostering the practitioner's self-knowledge and care for self:

There is an ethical responsibility to use supervision for appropriate personal and professional support and development, and to seek training and other opportunities for continuing professional development

(BACP 2007 p3)

Reference is made to supervision twice in the 'Providing a good standard of practice and care' section:

(a) 'Maintaining competent practice'

All counsellors, psychotherapists, trainers and supervisors are required to have regular and on-going formal supervision/consultative support for their work in accordance with professional requirements

(BACP 2007p5)

(b) 'Supervising and managing'

There is a general obligation for all counsellors, psychotherapists, supervisors and trainers to receive supervision/consultative support independently of any managerial relationships

(BACP 2007p6)

The terms 'obligation', 'ethical responsibility' and 'required' are directed towards the practitioners in guiding them towards participation in supervision, and the verbs 'to have', 'to use' and 'to receive' are used in relation to the inclusion of supervision in practice. There is an interesting balance of agency in the choice of these verbs: 'to receive' and 'to have' being passive, and 'to use' being much more active, implying the practitioners active engagement in the practice of supervision, as opposed simply to the more passive possession or receipt of it.

The problem of the value of supervision's evidence base

The personal communication with the BACP representative referred to on page 97 reinforces many of the concerns already highlighted in that she reiterated that whilst supervision is perceived to be a 'good thing', to date there is an insufficient evidence-base to support that. She assured me that the BACP is committed to the notion that even the most experienced practitioner needs supervision and that there are many

debates about how many hours should be required. However, research which could provide evidence of the value of supervision is more problematic, and appears to derive from a paradigm conflict. On the one hand, the counselling profession is eager to be seen as equal in status as other 'health' related professions as they are a relatively new profession and one which continues to struggle to be accepted as one (see section on the professions above on page 92). In order to achieve this aim, there is a sense that it needs to compete with the prevailing discourse of evidence-based practice where the gold standard continues to be the randomised control trial. There is a long tradition of this in the psychological therapies, as illustrated by the fact that cognitive behavioural therapy (CBT) was accepted as the only viable therapeutic treatment to be considered when the large amount of funding for the Access to Psychological Therapies was released by the Department of Health. Researchers into therapy have long argued that researching efficacy of therapeutic interventions is a complex process and needs alternative, qualitative and phenomenological methods. The assertion that there is very little reliable evidence of the effectiveness of supervision derives from a number of evaluations of the literature such as that undertaken by Ellis, Ladany and Krenzel in 1996. The problem here is that these very evaluations are themselves, open to the critique of being constrained within a medical paradigm and therefore rejecting of many rigorous studies which derive from more phenomenological and post-modern paradigms. The clamour for evidence-based practice accompanied with the convenience of certainty provided by these evaluations rather than taking the trouble to engage with the multi-dimensional complexities of other approaches arguably much more suited to evaluating the effectiveness of interpersonal, non-medical psychological therapies. Part of the difficulty here is that the psychological therapies include disciplines with diverse practice and research traditions themselves. This is particularly noticeable when looking at the differences between counselling and psychology. The research tradition in counselling draws much more substantially from ethnographic

methodologies from the social sciences and psychology places itself much more firmly within a scientific paradigm more consistent with a medical approach. It is from psychology that many of the quoted evaluations derive.

However, as described at the start of this section of the review on page 92 there are now plans to regulate counselling under the Health Professions Council (HPC). As indicated earlier, the regulation of counselling by the HPC is due to be implemented in 2011/12. It remains to be seen what impact this will have in terms of the wider influences. In personal communication with a representative from BACP with specific responsibility for Supervision and Continuing Professional Development (March 2008), it is clear that the prospective changes to regulation are expected to have an impact on supervision in counselling. The indication I received in this communication was that BACP is hoping to include supervision under the regulation of counselling Standards of Proficiency being constructed by the HPC. In addition, the HPC will be looking at the revalidation of registrants over a number of professions and BACP suggests that supervision could be included here, too. Currently, the BACP requires practitioners to provide evidence of supervision in order to achieve re-accreditation.

The HPC produces a number of documents of these 'Standards of Proficiency' documents, some of which are specific to one of the 14 professions it regulates (as at 2010), and some are generic for all professions. None of these 'Standards' searched (Arts Therapy, Occupational Therapy and Physiotherapy), 'Standards of Continuing Professional Development and your Registration', 'Standards of Conduct, Performance and Ethics' (HPC 2008) address clinical supervision and they only refer to supervision in terms of 'oversight' of less experienced practitioners. It will be a new departure for the HPC if the BACP is successful in including supervision in the standards of proficiency, though as the CPD documentation covers all the professions, they clearly are going to be unable to have it included there. It will be

interesting to see whether they are able to maintain their espoused commitment to its practice. The personal contact from the BACP did suggest that the Arts Therapists may have included this in their latest standards of proficiency in the last few months, but all that is included in the published documentation as at March 2008 is the statement:

*The skills required for the application of practice:
2c.2 be able to audit, reflect on and review practice:
recognise the role and value of clinical supervision in an arts therapy context
(HPC 2007 p12)*

The standards of proficiency are largely generic and shared across the professions. Profession-specific aspects in each document are printed in blue to distinguish them from these generic standards. This reference to clinical supervision in the Arts Therapists standards is in blue and does not appear in any of the other professions' documents (2007 versions).

4. The clinical psychology context

As indicated on page 92, at the time of writing, Clinical Psychology is one of seven domains of psychology within the British Psychological Society whose regulatory functions have recently transferred to the Health Professions Council (HPC).

During the protracted discussions and debates that led up to the implementation of this process, including the HPC and BPS responses to the original Department of Health consultation document, no references were made to supervision. The DH document only refers to supervision in terms of 'supervision or management'. There is no mention of clinical supervision within the discussion about regulation of psychology.

The Division of Clinical Psychology (DCP) has produced just three short publications on the topic of clinical supervision:

1. Policy Guidelines on Supervision in the practice of clinical psychology (BPS 2003)
2. Discussion Paper DCP Policy on Continued Supervision (BPS 2005)
3. Continued Supervision (BPS 2006)

From personal communication with the co-author of these documents (19th March 2008), she made the following points about the development of clinical supervision in clinical psychology:

- Clinical psychology is a relatively young profession. In the early days (from the speaker's experience, approximately 30 years ago), supervision was provided in training but it was not mandatory post-qualification.
- Until the recent policy was written which made it mandatory, many newer graduates were already undertaking it though not older ones. It is now seen as a necessary part of the job by the majority of people.
- Those who do not see this are gradually retiring.
- The profession's response in making it mandatory is basically as 'defensive practice': acting safely, ethically.
- It is top-down approach but pushing against an open door, as it embraces a culture of life-long learning, which exists amongst practitioners.
- Also, practitioners are aware of wanting to do their best for clients and of 'keeping themselves healthy'.

The DCP made clinical supervision mandatory as it believes it makes for better clinicians. Although the speaker emphasised to me that the research BPS has done

does not prove that, she also emphasised the existence of 'vast amounts' of anecdotal evidence from practitioners that supervision helps them think through complex situations and makes them more efficient practitioners and keeps them healthy. She was hopeful that more qualitative findings will be forthcoming.

At the time of the conversation, the DCP was working on the DROSS project (Development and Recognition of Supervisory Skills), where an agreement can be reached on the content and evaluation aspects of clinical supervision. It is hoped that this will inform the development of a supervision course for those of at least 2 years' post-qualification and the development of a register of supervisors. As at 2008, the guidance was that newly qualified clinical psychologists can supervise other professions (e.g. nurses) straight away.

The overall aim, from the DCP's perspective was expressed in terms of the need to do one's best for the recipients of services and secondly to keep the workforce healthy.

The speaker's observation of supervision in nursing was that 'they get one kind of supervision but are asking for another'. She considered that there is a persistent implication from the nursing profession is that supervision is something you have until you are proficient, but that nurses themselves actually want something different. Her perception was that there is a culture in nursing that, 'if you need supervision, you are somehow not doing the job properly'. She went on to suggest that this used to be the case in psychology, but not any longer. Psychology is moving away from the 'scientist practitioner' paradigm (where the practitioner is an objective observer of what is happening) towards the 'reflective practitioner' where the practitioner is developing personally and recognising one's own 'stuff'. Whilst some would still stick to the old paradigm, they are 'a dying breed' – 'the argument is won'. This was seen

to be demonstrated at the DCP conference once a year where it was noticeable that there are more conversations about trainees wanting input around reflective practice: The clear cut scientists are not as obvious as they were.

This conversation with this DCP representative contrasted quite starkly with some recent literature emerging from high profile academics within the discipline. Milne for example, writing in the British Psychological Society's own journal, the *British Journal of Clinical Psychology*, asserts a very strong 'hard science' agenda on the definition of clinical supervision. Milne has undertaken a 'best evidence' synthesis from a systematic review of 24 empirical studies of clinical supervision. The synthesis has been used to 'test and improve' a working definition derived from a 'logical analysis' (Milne 2007 p437). On his University website biography, Milne includes this statement "I have followed the 'scientist-practitioner' model throughout my career, resulting in over 80 peer-reviewed publications"

<http://www.ncl.ac.uk/nnp/staff/profile/d.l.milne> (accessed 02.05.08) demonstrating that there is still credibility to this approach within the professional discourse of psychology. Whilst it is tempting to challenge many aspects of Milne's 'empirical definition of clinical supervision', most particularly the way in which he, and others within the scientific paradigm before him (Ellis, Ladany and Krenzel 1996 for example), so confidently reject vast swathes of primary research evidence on the basis that they fail to meet inclusion criteria as defined in previous work by the same author(s). In Milne's case, 359 such studies were rejected, leaving only 24 to meet the self-imposed and self-defined criteria, allowing them the authority to assert the efficacy of their own proposed working definition for clinical supervision provided; a case of 'Petitio Principii' (a circular argument). It is inevitable that the conclusion can be proved when the original assumptions are taken for granted. However, if the scientific-practitioner paradigm is an acceptable one, then the consequences and outcomes of research undertaken within it will inevitably follow this course. It would

appear that the 'scientific practitioner' versus the 'reflective practitioner' paradigms continue to be unresolved within the psychological discourse.

In 2007, the DCP commissioned 'Mental Health Strategies' (MHS) to produce a marketing strategy as part of their restructuring activities of that year. The fact that this is described as a 'marketing' initiative, and its' title: *Understanding Customer needs of Clinical Psychology Services* reflect identification with a customer/consumer model. Indeed, in the introductory paragraph on the executive summary, direct marketing language is used and clarified:

For the purposes of this document the term customer refers to those financing services i.e. commissioners and managers of services, not patients who in this context would be perceived as consumers.

(MHS 2007 p1)

In some areas there are differences of opinion regarding counsellors and primary care mental health workers as to whether they should be based in specialist services or within practices and the impact this will have. It was suggested that supporting these professions within General Practices in terms of supervision would be seen as useful.

(MHS 2007 p36)

Unique Selling Points of Clinical Psychologists

Broad Knowledge Base

Range of approaches/modalities

Skills in Supervision

Ability to deal with complex presentations

Ability to work with teams, supporting service and organisational developments

Ability to offer oversight and 'umbrella' /consultancy

(MHS 2007 p38)

In other words, this report is recommending that the provision of supervision by clinical psychologists to other professions and those working at lower grades is a potential unique *selling point* and used as commodity in the NHS market-place.

Summary of the discourse of the professions

This final section of the literature review has sought to identify the dominant discourses to be found in the governmental, organisational and professional literature around the practice of supervision. These include the discourse around the professions' regulatory function, as well as discourses of care, quality, risk, professionalism and autonomy. Taken together, this professional discourse informs one of the three dominant discourses to be identified in the discursive frame: *supervision as safeguard*. In addition, discourses around the role of the professional for *self-monitoring* are also evident which relates closely to Foucault's ideas about the *carceral society*, being one which "indicates a regime of micro-relations and disciplines which operate through a complex web of self-subjugation" (Petersen and Bunton 1997 pxvii).

Two further dominant discourses derive from the wider literature review: *supervision as containment* and *supervision as development*. Each of these discourses informs the development of the discursive frame, which is the purpose of the next chapter.

Chapter six: Clinical supervision as a discursive frame

Introduction

The intention in this chapter is to outline the discursive frame constructed from three distinct discourses that have emerged through the preceding sections in the literature review. These discourses are identified as:

- Supervision as *containment*, with its roots in the therapeutic discourse
- Supervision as *development*, with its roots in the training discourse
- Supervision as *safeguard*, with its roots in the professional discourse

Consistent with Foucault's archaeological approach to knowledge, as outlined in the theoretical positioning chapter (chapter three), the historical and theoretical roots of each one will be outlined before a summary is provided of current concerns and themes, as identified in the literature review. These concerns will be located within the discourse in relation to the *discipline*, *author* and *commentary* of each discourse. In this way, the *discursive formations*, or *orders of knowledge* which shape the discourse can be articulated (see chapter three). This is summarised in a table at the end of the chapter. Distinguishing the discourses in this way may, for the first time, help to explain reasons behind longstanding and unresolved conflicted issues within the literature on supervision.

Supervision as Containment

In the opening chapter of the guide to supervision, 'Supervision in the Helping Professions' (2000), now into its third edition (published 2007), Hawkins and Shohet refer to Winnicott's concept of the 'good enough mother' as a metaphor for the *containing* purpose of supervision, as a place where the negative impacts of a practitioner's professional work can be held; where emotional disturbance can be survived, reflected upon and from which lessons can be learnt. In terms of object

relations theory, from which Winnicott's concept derives, the supervisor can take the role of 'mother' onto whom the supervisee (child) can project their 'bad' objects (Winnicott 1971).

This notion of containment, therefore, may be seen to derive from a psychoanalytic epistemology (Casement 1985), which would be consistent with a *therapeutic* origin of the practice of supervision, finding its roots in the kinds of supervision modelled by Freud, initially as a form of apprenticeship and latterly as an integral aspect of training in the practice of psychoanalysis. This discourse of supervision, therefore, is consistent with an approach where transference and counter-transference may be explored for insights into the therapeutic encounter and relationship. Several authors have identified approaches to supervision based on psychoanalytic models. (Watkins 1997; Rafferty 2000; Page and Woskett 2001; Ungar, Busch and Ahumada 2001). Ungar and Busch de Ahumada illustrate an approach built on the containment of unconscious anxieties and Rafferty writes of a conceptual model for clinical supervision based on Winnicott's theory of the parent-infant relationship.

The notion of supervision as *containment* is widespread within the literature, extending beyond the overtly psychoanalytic approaches into most of the known models of supervision (Stoltenberg and Delworth 1987; Hawkins and Shohet 2000; Page and Woskett 2001). In the second edition of their book, Page and Woskett introduce a "different way of picturing the cyclical model". In this new figure, the 'space' component becomes the container around which the four other components of their model (contract, bridge, focus and review) are situated. They have entitled this new figure 'The cyclical model as a container' (Page and Woskett 2001 p104).

The sense of security of the supervisor can provide a means of containment for the insecurities of the counsellor in relation to their counselling work
(Page and Woskett 2001 p121)

As one of only three functions identified in Proctor's almost universally accepted model of the functions of supervision, this *restorative* function is illustrative of one of the most persistently contested issues in supervision: that of the interface between supervision and therapy. The extent to which restorative activity and therapeutic activity are distinct is arguable and yet there is a persistent assertion within the literature that supervision and therapy should be kept as entirely distinct functions. Justification for this position is not always convincingly argued. Recognition of the history of the discourse of supervision as containment, which itself does not seem to be contested, may help to explain why this issue persists, and theoretical consistency may suggest that the tacit assumption that these two are such distinct practices needs revisiting.

Supervision as Development

The discourse of supervision as development can be seen to have its roots in the context of *training*. As identified above, the UK is relatively unusual in its culture of the practice of post-qualifying supervision and much of the influential literature on supervision derives from a context where supervision is provided only at pre-qualifying levels. This inevitably shapes the way supervision is conceived and it is from this context that developmental models of supervision have also been proposed (Stoltenberg and Delworth 1987). These models are based on the assumption that a developing practitioner needs to travel through a sequence of developmental stages in order to become proficient. Definitions of supervision drawing from this discourse also tend to characterise the supervisory relations as one between a senior and more junior practitioner, such as that offered by Bernard and Goodyear (Bernard and Goodyear 1998). Within a training context, the boundary between supervision as a *formative* process and an *evaluative* process is relatively undisputed; students of any subject would normally expect to be both assessed and enabled. However, in post-

qualifying environments, these two aspects take on very different associations. At the very heart of entering a profession lies the expectation that a practitioner is now entrusted with a mandate to practise relatively autonomously. So whilst supervision's formative function is relatively unproblematic, any evaluative function attributed to it risks conflating clinical and managerial supervision as well as the potential for practitioners to view it with suspicion. Fish and Twinn (1997), in attempting to make the distinction clear to a wide audience of 'health care professionals': assert

our definition of supervisor – whomever the supervisee works with – is not that of 'overseeing manager' but of 'educational collaborator'
(Fish and Twinn 1997 p2).

Their approach focuses on professional development rather than initial training:

clinical supervision as rooted firmly in education rather than in training and regards the clinical supervisor as an agent of professional development rather than as a control mechanism.
(Fish and Twinn 1997 p3).

But nonetheless, its emphasis on education illustrates a commitment to supervision as development as an ongoing process.

Zorga (2002) also proposes a model whereby supervision can be seen as a process of lifelong learning, the 'developmental-educational model of supervision':

In this context, supervision is understood as a specific learning, developmental and supportive method of professional reflection and counselling, enabling professional workers ...to acquire new professional and personal insights through their own experiences
(Zorga 2002 p265).

In this model, she disputes Kadushin's (1992) hierarchical structure of the supervisor/supervisee relationship. She argues that "supervisees should come, if possible, from different working organisations or at least from different departments of the organisation" enabling workers to "talk about their worries, fears, work problems and mistakes more openly and with greater freedom". Her argument is that this approach enables and encourages the exploration of "more options, more approaches to the problem, more levels of thinking":

Once we have recognised the meaning of an experience or an event, we frequently come to the realisation that it is actually an experience of several generations, which has already been recorded in numerous professional papers. It is, however, necessary that we come to such an enlightenment by ourselves. Once the experience and the meaning have been integrated, they become our wisdom... That means that in supervision, work, education and personal development are linked together through the process of experiential learning.

(Zorga 2002 pp265-267)

In this way, Zorga locates her model in a developmental frame, drawing from the work of Kolb and his foundational writing on experiential learning (Kolb 1984):

The use of experience in the supervision process corresponds to Kolb's model of learning as a cyclical process in which four activities interact: the concrete experience, its reflection, its abstract conceptualisation and experimentation.

(Zorga 2002 p268).

The supervisor's role is, therefore, to guide workers in their learning cycle. This is why, Zorga argues, the role of the supervisor is different to that of mentor (or preceptor) whose role is involved primarily in instructing, advising, monitoring, guiding etc. "That is why the supervisor should be primarily an expert in supervision, while a mentor must be an expert in the same profession" (Zorga 2002 p268).

Other writers express the need to articulate the learning potential of clinical supervision in order that it remains relevant through and beyond qualification (Brigley and Robbe 2005; Bruijn, Busari and Wolf 2006; Launer 2006).

In the same way that acceptance of the assumption that supervision should not be therapy seems to have attained the status of a 'given', so too has acceptance that an effective practitioner is one who engages in reflective practice and that supervision is a forum in which this should be encouraged and developed. It appears to be widely accepted as a means by which a professional can develop the requisite complex skills which will enable him/her to become a capable and autonomous practitioner,

drawing from the influential writing of Schön and others (Schön 1983; 1987) and now firmly embedded in most professional education programmes. There have, however, been some challenges to this assumption in the literature and these are explored in depth in the discussion. For the purposes of the construction of the discursive frame, it is important to include the discourses around reflective practice as part of the dominant discourse of supervision as development.

Supervision as Safeguard

Three related discourses around safeguarding can be identified:

- safeguarding the public
- safeguarding the client
- safeguarding the profession

Safeguarding the public

The roots of the discourse of supervision as safeguarding the public can be traced back to the historical context from which current mental health practice derives. Historically, asylums for the treatment of the mentally ill find their roots in the penal system and only in the mid nineteenth century did they begin to be run by medical professionals. (McCallum 1997 p59). The dual function of mental health practice as to both treat the patient and protect the public from criminal behaviour continues to this day. Only in the field of mental health are the two systems of health and criminal justice so closely allied. As McCallum argues, there is a persistent problem in separating medicine from morals, as evidenced in the 1983 Mental Health Act which includes guidelines for hospitalisation as well as for the criminal justice system. As McCallum recognises “whether or not personality disorder is a mental illness is an ongoing source of controversy between the [legal and health] sectors” (McCallum 1997 p55). This is an important background which continues to influence mental

health practice, as seen in the system of the legal right of Approved Mental Health Practitioners to commit a person to a secure unit, for example.

Safeguarding the client

Whilst an emphasis on client welfare can be located within the history of trainee supervision (Feltham and Dryden 1994), its history within practitioner supervision is less clear. For example, in his paper 'Supervision: a tale of the missing client', Mearns (1995) argues that the client only exists as the supervisee presents him/her and whilst making sense of the client may bring a sense of security, it does not necessarily bear any relation to the actual reality of the client. It could be inferred that he is suggesting that this leaves the client somewhat vulnerable, but he does not make this explicit. King and Wheeler (1999), in their qualitative study into the responsibilities of counsellor supervisors, express concern at the apparent lack of clarity expressed by supervisors about their responsibility towards the welfare of the client. Given that supervision is a vicarious activity (in that the focus of the discussion, the client, is not present), the supervisor can never really know what goes on between the counsellor and the client. The counsellor generally chooses what to bring and what not to bring to supervision, so may withhold information that suggests s/he has practised unethically, illegally or in an inappropriate way. This has important implications for the extent to which a supervisor can then be responsible for the work of the supervisee, and by implication the benefit of the client.

Recommendations are made in relation to membership of professional bodies, contracts with employing agencies etc, but this then raises the frequently debated issue of the relationship between *clinical* and *management* supervision. The extent to which supervision can be conflated with managerial supervision is a contentious issue in all healthcare professions, as described in section three of the literature review. The arrival of Clinical Governance into the National Health Service linked

supervision and safeguarding the public together for the first time (DH 1998), which suggested that clinical supervision had an important role to play in clinical governance and, by implication, surveillance and safeguarding. In so doing, the potential for clinical and management supervision to be conflated was increased.

An assumption frequently made about the role of supervision in protecting the client is that the more honest a supervisee is enabled to be in their supervision, the more likely they are to discuss and talk about 'mistakes' without fear of management consequences. The tension for the supervisor is seen as one of balancing a potential need to be accountable to line management where client safety may be at risk and the need to provide a confidential space in which the supervisee might explore anxieties and possible mistakes. Both Faugier and Yegdich emphasise the dangers of conflating managerial supervision and clinical supervision, the latter quoting the term coined by Burton (1930) in the 1930s: 'snoopervision', where "supervisors manipulate subordinates' behaviour to reach the goal of the organisation through the use of administrative principles" (Faugier 1994; Yegdich 1999a p1199).

However, the distinction between clinical and managerial supervision is not entirely clear cut. For example, Cutcliffe and Lowe, in their paper on the comparison of conceptualisations of clinical supervision between North America and Europe, highlight differences in respect of the role of management and accountability within the process of clinical supervision, recognising that this carries a much higher profile in North America (Cutcliffe and Lowe 2005), though this may well derive from the training context of supervision in North America, as described above.

The argument that the provision of a safe place where mistakes can be explored will, in itself, provide a safeguard for the client, rests on the assumption that the client is better protected when issues can be brought into the open in a 'no-blame'

environment and solutions found through exploration in the supervision. This notion of using supervision to reflect on one's actions and responses to those actions is another reason given for the benefit of using supervision for reflection and links back to the discourse of supervision as development (above) in that 'reflection' is seen as integral to professional learning. However, this approach towards reflection in supervision is not universally welcomed. In her 2001 paper, 'Private Thoughts in Public Spheres: issues in reflection and reflective practices in nursing', Cotton challenges what she calls the 'hegemonic discourse of reflection in nursing' (Cotton 2001 p512). There has been an intriguing debate in the literature around the extent to which reflection in supervision is a form of implicit surveillance

When clinical supervision is conflated with managerial supervision, it ceases to be an emancipatory process and becomes analogous to Bentham's 'Panopticon'; a process more concerned with surveillance and Foucault's notion of 'the gaze'

(Gilbert 2001)

Or, on the contrary, a forum for 'emancipatory' interests (Johns 2001). This relates directly to Foucault's interests in power and the way it shifts between an external 'gaze' and an internal self-surveillance, the 'technologies of the self' (Foucault 1977; 1986; Clouder and Sellars 2004; Rolfe and Gardner 2006). This theme is central to this current study and is explored in detail in the discussion chapter (chapter eight).

Safeguarding the profession

The role of supervision as safeguard of the profession is less clearly identifiable in terms of its roots. Whilst the roots of the role of the professional body as a guardian of the profession itself are explored in detail in the literature review, the contribution of supervision itself to this guardianship is less easy to identify. Its role in inducting junior members of the profession into the knowledge, skills and cultural understandings of the profession is arguable, as is the extent to which the supervisor evaluates the supervisee (or encourages the supervisee's self-evaluation) is set within a framework of assumptions and expectations of the given profession and

local contexts. Whether supervision also has a role in critiquing and questioning these assumptions has been argued by Fish and Twinn but few others (Fish and Twinn 1997). Nonetheless, as evidenced in the literature review, each of the professional bodies representing the three professions has produced some guidance on the practice of supervision, most usually framed within the ethic codes of practice, themselves a characteristic feature of a 'profession' (BPS 2003; BACP 2007 (first published 2002); NMC 2008).

Drawing from Habermas' theory of *knowledge-constitutive interests* (Habermas 1971), Johns suggests that "the rhetoric and spirit of supervision would suggest an emancipatory approach yet the reality is that when supervision is accommodated within bureaucratic cultures, the technical interest will be dominant, especially when supervisors are in line-management roles to practitioners... While the espoused approach to supervision is genuinely grounded in the practitioner's best interests, the reality is that supervision is more likely to be implemented from an organisational perspective whereby the ideal model of clinical supervision is accommodated within the existing bureaucratic culture despite intent to the contrary" (Johns 2001 p140). "viewed from another angle, the tension between technical and emancipatory interests within the supervisory relationship can be seen to be paralleled within clinical practice within the tension of managing risk and being therapeutic" (Johns 2001 p144). Johns supports his argument for pursuing the emancipatory interest in clinical supervision by referring to the NHS Management Executive publication of 1993: *A Vision for the Future*, where emphasis is placed on one of the goals of supervision being for the practitioner to "assume responsibility for their own practice..." (DH 1993 p3). He develops these ideas in a later paper (Johns 2003) where he explores the development of nursing leadership through the process of clinical supervision. "Clinical supervision may provide a congruent learning opportunity to develop transformational leaders within nursing." (p26). The

conclusion he draws from his project is that it was “constrained by the organisational culture” (p33). “The leaders were willing yet generally unable to significantly develop their leadership ability” (p33). It is not clear why he makes this conclusion, rather than proposing that clinical supervision may not, after all, be the best means of developing leadership.

In summary

The intention of this chapter has been to articulate three dominant discourses, or ‘discursive formations’ of supervision suggested by the literature. By tracing the origins of each it has been possible to locate the themes and concerns identified in the literature within the distinct discourses and mapped against the disciplines, authors and commentaries that comprise the aspects of each discursive formation as described in chapter three. This frame is illustrated in the table below.

This frame is used as the basis from which the empirical data, gathered through the supervision sessions and interviews, will be analysed, to see in what ways participants drew from, or resisted, these dominant discourses.

A proposed discursive frame of the three dominant discourses in supervision comprising key disciplines, author and commentaries

Supervision as Containment		
Discipline	Author	Commentary*
Psychoanalysis	Freud	The prevailing model of <i>one-to-one supervision</i> , reflective of the one-to-one nature of the therapeutic relationship
Much counselling	Bion	Focus on the quality of the supervisory <i>relationship</i>
Research paradigms include exploratory, qualitative, discursive and narrative approaches	Mearns	Preference for a <i>non-directive style</i> of supervision
	Grant	Reliance on a <i>therapeutic orientation</i> as a supervisory style
	Yegdich	Recognising the potential of supervision as a means to <i>reduce anxiety</i> and to alleviate the potential for <i>stress and burnout</i>
	Gilbert	Awareness of the <i>boundaries</i> of supervision, including its <i>confidential</i> nature
	Rolfe	A focus on the <i>caring</i> nature of professional activity
	Sloan	A focus on <i>person-centred</i> models of care
	Stevenson	The <i>restorative function</i> of supervision of Proctor's model
Supervision as Development		
Discipline	Author	Commentary
Reflective practice	Benner	The <i>formative</i> function of supervision (from Proctor)
Much psychology	Johns	<i>Reflective practice</i> and its expectation of self-monitoring
Education and training	Butterworth	<i>Group models</i> of supervision The <i>role modelling</i> function of supervision ('learn from me')
Research paradigms are consistent with those above	Cutcliffe	The focus on the need for ongoing <i>training</i> , including in supervision
	Holloway	
	Proctor	
Supervision as Safeguard		
Discipline	Author	Commentary
Much nursing	Milne	The normative function of Proctor's model
The professions	Hykas	Multi-disciplinary models of supervision
Evaluation and efficacy	Winstanley	A focus on inducting the supervisee into the culture and practice of their new profession
Research paradigms include evidence-based approaches, quantitative methods	Professional documentation	The more directive styles of supervision
		A focus on supervision as a forum for developing professional leaders
		Focus on professional concerns, constraints and identity
		Focus on safeguarding the public, public accountability and managing risk
		Concerns with protecting the profession
		Focus on recruitment and retention issues

Table 2 discursive frame summary

* These column headings have distinct meanings, drawn from Foucault's conceptualisation of the constituents of discursive formations. These are outlined in chapter three and are not necessarily consistent with the more usual meaning associated with the terms.

Chapter seven: Analysis

Introduction

As indicated in the methodology, this analysis is not thematic. The intention is to map the discourses of the research participants against the discursive frame outlined in the previous chapter and, in so doing, to identify ways in which the participants draw from, or resist the dominant discourses. In addition, in line with the process suggested by both Cheek (2004) and Kendal and Wickham(1999) and described in the methodology chapter, the transcripts are also analysed for evidence of:

- implicit rules governing the way in which the participants talk about supervision
- ways in which the relations of power might be constructed and negotiated.

Summaries of these rules and the relations of power are provided at the end of each section of the analysis.

Analysis begins with the three dominant discourses outlined in the discursive frame and it will be demonstrated that the data confirms the dominance of these discourses in the way the participants talk about their supervision experiences. However, the transcripts also show evidence of the participants drawing from an additional discourse which I have called the discourse of *supervision as nourishment*. The implications of this additional discourse are picked up in the discussion.

Each of these discourses can be seen as a discursive formation, comprising a number of contingent aspects. These aspects form subsections of the analysis, summarised in a table at the beginning of each section

Many of the quotes are long. This is intentional as my approach to the discourse is to try and observe it *within context*, and specifically *not* to attempt to break it down to

the level of individual words. My intention is always to reflect the meaning-in-use and therefore this demands that any specific word or phrase that is of interest needs to be situated (Cheek 2004) within the whole spoken section.

Supervision as Containment

Discursive formation	aspects	Contingent aspects
Supervision as containment	1. Psychoanalytic tradition 2. Holding 3. Confidentiality 4. Boundaries 5. Managing anxiety 6. Therapy	

Table 3 summary of aspects contained within the discourse of supervision as containment

2959: but my consistent experience for her was that I couldn't contain it for her either and I worried that there might well be something about my style that was making a contribution to that. So I do, yes, I do worry about it and I don't think... I don't I've always been successful in making it fit if you like.

This reflective comment made by the clinical psychology supervisor illustrates how important it was to him to provide a containing environment for his supervisees, and how it bothered him when he considered himself unable to do so. It is indicative of a tacit acceptance of the *supervision as containment* discourse.

1. The psychoanalytic tradition

Assumptions about the containing nature of supervision were deeply embedded in the discourse of each of the participants and there were many examples of participants drawing from, psychoanalytic concepts (from which the *supervision as containment* discourse derives) though almost entirely implicitly. Amongst the interviewees, only one (the nursing supervisor) demonstrated evidence of drawing from the psychoanalytic approach in his chosen use of terminology. His use of terms deriving from that tradition included:

- Splitting:

11082: *The way I would see it is that within an organisation the tendency is to split in stress, splitting. One obvious form of splitting [inaudible]. I was talking about a very interesting ... session, and er, where if you can keep, take not necessarily the split and then things will be simple. And, er, it isn't being able to integrate and hold things together*

- Transference and counter transference:

14687: *elements of mirroring between what's happening in work and then what's happening outside work. Transference and counter-transference issues, um, so I suppose, you know, I would take a ... it ... I'd, I'd take a broad view of, of what supervision ... of what constitutes supervision, um, was really the only ... the only kind of, yes I suppose the boundary would be that it had, that ... that it needed to make a connection with the work.*

- The use of metaphor:

14251: *But that kind of describes your position work a little bit, isn't it? You kind of.... you're stuck in this.... you're stuck on.... stuck on this road that you're not that happy about, but you don't know which.... how to change it.*

(This comment was made by the supervisor to his supervisee after she described an actual incident of being stuck on the road behind an accident and wondering whether she should turn around and take another road.)

Several further examples of the use of metaphor for this purpose can be found in the discourse of the nursing supervision session.

2. Holding

However, despite the psychoanalytic discourse being very noticeable in the nursing transcripts, neither the nursing supervisor nor his supervisee ever directly discussed the holding/containing nature of supervision. This aspect of supervision was much more prevalent in the discourses of both the clinical psychology and the counselling transcripts. Use of words such as 'contain', 'hold', 'confidential' and 'boundary' appeared repeatedly in their conversations, both in the interviews with me and in supervision sessions themselves.

For example, in the first clinical psychology supervisee interview:

3178: Typically where I am at the moment I think with things is that I need to, because I am fairly newly qualified, it feels containing for me to get a handle on the way the processes that allow us to do the work of psychology.

And in the second interview with the same participant:

9660: there's something liberating but containing at the same time about working with somebody who it feels like has very much had a similar experience to me at some point in their career, earlier

And in the second interview with the counselling supervisor:

7390: You want to hold onto the supervisee and hopefully keep them onboard and enable them to learn from the experience and move on in a positive way

Here, the clinical psychology supervisor is telling me about one supervisee where their supervisory relationship was troubling:

2959: but my consistent experience for her was that I couldn't contain it for her either and I worried that there might well be something about my style that was making a contribution to that.

In supervision sessions, both supervisors and supervisees referred to aspects of containment when discussing cases:

The counselling supervisor to her supervisee in the first recorded session:

243: Yes and I think that was very important because that... the boundary was important because that contains her grief. Um I think you err handled a very difficult situation very well. Very well. And what about what she was telling you?"

And the clinical psychology supervisee to his supervisor in their first recorded session:

2463: He [the client] also knew that if things got worse and he couldn't handle it in some way that he'd get back on the waiting list, so that containment seemed to really help. And then he went off and just carried on with his life

This was picked up by his supervisor a few lines later:

2485: being... being contained, as you say, and held and that kind of being topped and tailed by a meeting, or a couple of meetings is enough.

This became a sustained topic in this session:

2490: (supervisor) *I think to put some containment on the idea of what was... what was wrong with this guy, to put it into language...*

The notion of containment was frequently evident in the transcripts both when participants were discussing the supervision process but also when discussing their direct work with clients. This 'mirroring' of a similar process is recognised in the psychoanalytic tradition as a 'parallel process' where it is considered to be an integral tool for exploring interpersonal dynamics. The fact that the participants did not explicitly connect their understandings about containment to a psychoanalytic process suggests that the assumptions were deeply embedded. Furthermore, in *not* speaking of these roots, there is no opportunity to resist or challenge these assumptions.

In accepting the notion that supervision has a containing quality, the supervisor is accorded a powerful role, as it is the supervisor who assumes the Winnicottian parental role and contains both the supervisee and the content of the supervision session. Examples from the extracts above illustrated that this power is both given to the supervisor by the supervisee:

9660: *there's something liberating but containing at the same time about working with somebody who it feels like has very much had a similar experience to me at some point in their career, earlier*

And accepted by the supervisor:

2959: *but my consistent experience for her was that I couldn't contain it for her either and I worried that there might well be something about my style that was making a contribution to that.*

Additional concepts drawn from the discourse of *supervision as containment* were also frequently evident in the transcripts. These include *confidentiality*, *boundaries*, *managing anxiety* and *therapy*.

3. Confidentiality

The ways in which supervision serves to provide a safe and confidential space was only ever alluded to in relation to the context within which the supervision was taking place and the perceived challenges to the assumed confidential nature of the supervisory conversations. By the time of the third round of interviews (two years after the first round), the external environment for the counselling supervisor had changed considerably, and to the extent that she was no longer working with the counselling supervisee who had participated in the first two rounds of data collection. A new supervisee had agreed to take part but the effect of reorganisation meant that their work had changed considerably and now included much activity that was on the periphery of counselling practice, including some activities more readily associated with occupational health, such as workstation assessments. Both the supervisor and supervisee demonstrated remarkable resilience in attempting to maintain their counselling values in these changing circumstances, which illustrates just how deeply embedded was the discourse of supervision as containment. An indicative example of this can be found in my second interview with the counselling supervisor:

7130 I think there is a role for Supervisors to, particularly in organisations, be more visible. But I think, you know, you need to think very carefully about how you do that and maintain a safe, secure, confidential supervision space. Um, and I think it's not easy. It's not just you suddenly appear at a management meeting and start speaking freely. I think it has to be, you know, management information that's fed back in a form that's obviously not identifiable.

Similarly, in my final interview with the counselling supervisor:

13154: And, um, she's done really well to, to hold on. And what we try to do is hold on to her, the core of her counselling, um, practice, and adapt it to sort of some very, um, well constantly changing, um, organisational criteria

And in my somewhat stumbling reflection back to this supervisor a few lines later, she affirms that her supervisory framework provides a container for holding all the complexities of working in these changed circumstances:

13334 ... you say there's no rule book, but what I hear when you talk about supervision is that because you have a very clearly articulated framework, which I know we've talked about before, it sounds to me as though that gives you the freedom to then more or less do whatever, you know, to be flexible in the sessions and with, with your supervisees, because you've got an overarching framework that you feel is the right one, and it, and it, and it'll work, you know And so it gives you that kind of ...

Which prompts the response from the supervisor:

13343: *It holds us all, doesn't it?*

Discussion around the *limits* of confidentiality within the supervisory relationship was notable by its absence. For example, in my final interview with the counselling supervisee, I was asking her what would happen if she disclosed to her supervisor some action that could be deemed to be unethical. The supervisee was very clear that the supervisor would, indeed *should*, break confidentiality in those circumstances and refer it to the supervisee's manager:

13795: *I mean I ... it's not something that we've actually, um, discussed. But to me it goes without saying that that is part of your supervision.*

Likewise, in the mental health nursing context, a new supervision policy was being circulated. Whilst highlighting the differences between managerial and clinical supervision, it also included guidance about information-sharing between the two supervisors, thus challenging again the confidential nature of the supervisory relationship:

4722: *and there's a...an explicit expectation that there's sort of contact between the management and clinical supervisor, you know.....so that...that unnerved, particularly sort of therapists, you know...*

And in the second recorded clinical psychology session, the participants are discussing a new policy document in which it appears that they are being asked to make available notes of their supervision sessions. The supervisor comments:

8913: *You know, it feels to me like it's... it's a private... private conversation. I can't imagine circumstances under which, err, I would feel happy anyone having access to the things that we've talked about...*

I am inferring from this comment that the limits of confidentiality had not previously been discussed between them and it is only when those tacit assumptions are questioned that expectations are made explicit. This is, perhaps an example, of the 'common sense' status afforded to this component of supervision that its confidential nature is assumed as understood by everyone. This is problematic when this is challenged by the context within which the supervision is taking place and also inhibits the extent to which any resistance to it can be expressed.

4. Boundaries

The notion of boundaries is a common one in supervision and also draws from the discourse of *supervision as containment*; a container *holds* its contents but it also provides a limitation, or *boundary*, to what is inside and what is outside. Reference to boundaries could be found in all three supervisory relationships. It was evident in discussions about supervision as well as in discussions about cases, illustrating again, the mirroring of processes between the various relationships. For example, in my final interview with the mental health nursing supervisor, boundaries of supervision are discussed:

14652 : um ... but I suppose, I guess it was all ... [supervision is] always within a work context. It's in ... it's always in a context, in that the conversation is always in a context of her relationship with her relations and with her colleagues. Um, I [inaudible 15:09] holds the boundary of supervision.

The clinical psychology supervisee also alluded to the idea that his supervisor protected the boundary:

3268: It feels like he is gently bringing me on almost, in some ways. Allowing me enough...[laughs].. I don't want this to sound like, it is a bit like being a dog on a lead, one of those leads where it just extends out and out and out. So the dog feels as though he is having a good run around, but at the same time somebody... somebody is gently walking around the field. ... I need to know the parameters in a way that allow me to do the work more effectively.

And in the first recorded counselling supervision session, where the supervisee is referring to the way in which she didn't allow a counselling session to overrun, the boundaries of the relationship between counsellor and client form part of the supervisory conversation:

237: Supervisee: *So I'm aware of that boundary*
 Supervisor: *Yes and I think that was very important because that... the boundary was important because that contains her grief. Um I think you err handled a very difficult situation very well. Very well. And what about what she was telling you?*

In reflecting on this with me in the subsequent interview, the supervisor commented:

910: *I read an article a while back and it ... talking about, um, what ... working with the elderly and in ... in people's homes and needing to have bouncy castle boundaries that, you know, that lovely sort of squashiness. That the boundaries are so important. In fact in a way they're more important. And I find myself talking about boundaries more often than perhaps anything else at the moment.*

So whilst enjoying the notion of boundaries being flexible, or *squashy*, this supervisor was clear: boundaries in work with clients are very important and need to be discussed often with supervisees.

As I have suggested, participants rarely referred to explicit theories or moments in time when they first learnt about a particular concept. But one notable exception to this was the counselling supervisee's memory of writing an assignment whilst a student:

1425: *And we had to write a... 3000 word essay about supervision....the boundaries, and the differences between supervision and counselling, and the relationship you know, that...*

This comment reflects the supervisee's experience of learning about the importance of boundaries and the fact that supervision is not therapy. These were the only two specific aspects of supervision that she could recall learning about in training, and may suggest that these were aspects particularly emphasised by the trainers, which would be consistent with my suggestion about the assumed importance of both of

these aspects of supervision, which suggests a dominant focus on the discourse of *supervision as containment*.

Similarly, the clinical psychologist supervisee referred back to his training in relation to his understandings about the boundaries of supervision:

3530: *I would suspect that that is That's.... yes, certainly recognised between the two of us, an unspoken rule if you like. And that seems to be my experience throughout as well. It would just seem inappropriate. Perhaps that is one thing that I have picked up from training and that session on supervision as well. I think... you have reminded me now, I need to go back to those notes, but I think boundary issues were discussed in a kind of open forum there as well. Err, in fact, actually now you remind me of it, I am pretty sure, and I don't know why these memories are coming back now, um we were given a kind of mini questionnaire at the start of, you know, let's talk about your experience of supervision. And they were also around what are your boundaries for clients as well, so that the workshop if you like may well have been about boundaries, of which supervision was discussed as part of that.*

5. Managing anxiety

The containing nature of supervision is described as a 'godsend' by the counselling supervisee (13463). She describes it in this way:

13489: *my anxiety builds and sometimes ... most of the time, nine out of ten times I manage it but there'll be that one occasion where it sometimes runs away with itself. And G will actually, I suppose, help me to reel that back in*

Words such as 'runs away' and 'reel back in' being illustrative of an image of supervision as containing anxiety.

Interestingly, neither the nursing nor the psychology supervisees speak of supervision as a place for containing anxiety, and raises questions as to why this well documented process barely features in the transcripts. Perhaps the term *anxiety* relates to closely with the affective domain, in that to talk about anxiety comes very close to talking about 'feelings' and 'emotions', terms more closely allied to a therapeutic encounter. Perhaps anxiety has become *unsayable* in the supervisory

encounter as to do so would be to permit a therapeutic aspect to supervision, something which is strongly resisted, both in the literature, and in the transcript data.

6. Therapy

The prevalent assumption that supervision is not, and must never become, therapy was reiterated to me on a number of occasions such as this one by the mental health nurse supervisee:

5106 so I've always been...you know, you're always warned against the risks of falling into a...a counselling situation...

The relationship between supervision and therapy was often spoken about in relation to boundaries. For example, the mental health nursing supervisor reflects to his supervisee, almost by way of re-establishing the boundaries of what may and may not be discussed within the supervision session as the conversation perhaps begins to veer towards therapy.

Indeed, on reflecting on this in the subsequent interview with me, the supervisor stated:

14603: Well I mean the process that went on was something between supervision and therapy and ... it was ... it was an appropriate subject for supervision, um ... but at the boundary between, um, the work and ... and J as an individual really, and ... this was about J's experiences of her work or of her role.

Likewise, the clinical psychology supervisee was clear in his first interview with me that the boundaries of supervision clearly indicate that therapy is on the *outside* of the supervisory container:

3513: For me it seems fairly clear that there are things... there are enough things to discuss in supervision as it is. My feelings about clients are useful inasmuch as they inform the therapy, and that is the boundary of supervision in a way. There is no need to go beyond that.

Likewise, the mental health nurse supervisee expressed a similar position:

13630: *I would still bring it because it would all be connected somehow. Er, I mean if it was a completely personal, um ... issue that was in no way connected to my work, no I wouldn't. That ... because I would need a counselling session basically, which is not what supervision is about.*

However, the boundary is not always clearly defined. In my second interview with the mental health nurse supervisor, he was more ambivalent about the distinction:

11000: *Um, I would see my role in not making interpretations, I'm not a therapist. But I would make those observations. Um, and maybe say something like I've just said to you there, kind of feel that the difficulty in the workplace is overshadowing the difficult [inaudible – 21.50] Um, and er, but, I spoke earlier about parallel processes, and I think, I think it's helpful to bring both together. I think there might well have been something about that client, in that, that influenced the way that session went. I think it would be interesting to say something about that.*

This comment was made following the third supervision session in which this same supervisor commented to his supervisee:

14258: *And I'm just needing to, I suppose, remind myself that this is supervision, not therapy*

perhaps indicating that he was finding it difficult to hold that line. In the interview following this session, he commented to me:

14603: *Well I mean the process that went on was something between supervision and therapy and ... it was ... it was an appropriate subject for supervision, um ... but at the boundary between, um, the work and ... and J as an individual really, and ... this was about J's experiences of her work or of her role. ... That is a boundary you see, it ... you know, the therapy is about challenge isn't it and this was really on that cusp....*

And a few lines later:

14647: *Um, and so I mean the supervision kind of came on to her need to be an ideal carer, um, and take care of others at her own expense. Um ... and how she might do some things to look after herself, um ... I don't, yeah I mean, you know, just saying that, you know, is very much the stuff of therapy it's ...*

Similarly, the counselling supervisee recognised that some of the context of the supervision session was almost therapy, and she justified it by explaining that it was important to develop self-awareness:

7574: she [her supervisor] taught me to look at my stuff because how could I have been with her [the client] really if I didn't have work on my own stuff

Suggesting that whilst it may not be possible to talk about anxiety, it is possible to talk about self-awareness. This may be because notions of self-awareness can be seen to derive from the discourse of supervision as development, where an emphasis on reflection and reflective practice actually requires the development of self-awareness.

What was more often commented on was the way in which some supervisory processes were similar to those that take place in therapy. For example, the clinical psychology supervisee said, in his first interview with me:

3635: I do think there is an overlap between the therapeutic relationship you have with a client, which enables you to do some aspects of the work, and I also think there is an overlap with some of that with the work that you do in therapy..... in supervision.

And his supervisor commented to me in our first interview:

2732: I do supervision somewhat similarly to how I try to work with a client or with um... families and that is to... to try and find out from them first of all how they see the world and what they think they need and then to see if I can get alongside that somehow and give them what I think um... is going to be most helpful given their... their... their sort of needs.

And the nursing supervisor:

5104 which has been, um, I don't know I...I've, err, you know, tried to use the sort of...a counselling skills approach but, err, you know, I've also discovered, you know, supervision's supposedly very different to, um counselling, so I've always been...you know, you're always warned against the risks of falling into a...a counselling situation...

Relations of power within the discourse of supervision as containment

In drawing from the discourse of *supervision as containment*, the supervisor and supervisee are necessarily accepting an unbalanced power relationship: the 'container' and the 'contained'. The container needs always to be stronger than its contents, otherwise the container will break and the contents be spilled. It is

incumbent upon both participants to maintain this balance in order to maintain the supervisory relationship. In turn, this influence what can and can't be said. There is not a single example in any of the transcript data of a supervisee suggesting that they may be outgrowing the container, and yet many references to the value of being held. And despite some reflective anxieties expressed by supervisors about their own roles, none of them gives any suggestion that their ability to continue to contain is challenged.

Summary of rules governing the discourse of supervision as containment

1. Supervision should be containing for the supervisee.
2. Therapeutic concepts are relevant to the practice of supervision, though explicit reference to their roots in the psychoanalytic tradition are in some way un-sayable.
3. Supervision should be confidential and the passing on of information discussed in supervision has to be managed, but the limits of this confidentiality are only tacitly held.
4. Boundaries exist, both in supervision and in practice, and can be talked about explicitly, as they are explicitly emphasised in training, thereby sanctioning the discourse. However, these boundaries are '*squashy*' boundaries and the limits of this '*lovely squashiness*' are is not explicitly discussed.
5. In some contexts, it may be impossible to talk of supervision as a container for anxiety.
6. That supervision is not therapy needs to be repeatedly emphasised, and aspects of the supervision session that could be seen to be therapeutic need to be reframed into something more acceptable – such as being 'at the boundary of work and the individual'.

7. It's ok to talk about supervision as being in some way 'parallel' to the therapeutic process with the client, but absolutely not 'ok' to recognise that supervision itself may be a form of therapy.

Supervision as Development

Discursive formation	aspects	Contingent aspects
Supervision as development	1. Training and reflective practice	
	2. Taxonomy of stages of development	2a In training 2b Newly qualified 2c Gaining experience 2d Experienced
	3. Changing supervisor	
	4. Supervisor role in enabling development through phases	

Table 4 summary of aspects contained within the discourse of supervision as development

1. Training and reflective practice

The roots of the discourse of *supervision as development*, as explored in the previous chapter, have given rise to a number of assumptions. These include

- the relationship between supervision, training and continuing professional development and some of the potential conflicts that arise as a consequence
- the assumed benefits of reflective practice, particularly in respect to its role in experiential learning and emancipatory interests

Analysis of the data identified many examples of the discourse that drew substantially from these assumptions. Participants spoke about supervision as development in relation to supervisee development and the development of their practice, but also included the development of the supervisor as integral to the supervision process.

The counselling supervisor made explicit reference to the educative/formative role of supervision, indicating at least an implicit awareness of its roots in the formulations of the functions of supervision deriving from both Kadushin and Proctor (Kadushin 1992; Proctor 1994):

6929: *I think there is an educative role in supervision*

The nursing supervisor also drew parallels between his Trust's published supervision policy and these accepted functions of supervision, again indicating his awareness of the widely accepted functions of supervision.

5011: *There are 4 headings of, um, sort of support and, err, development and information, um...I can't remember the other one; but they're...they're similar to the...to the, um, err, areas of sup...that supervision is supposed to address according to the various models...*

2. Taxonomy of stages of development

As analysis of the ways in which the participants spoke about supervision as development progressed, it became clear that a hierarchy, or *taxonomy*, was emerging through repeated extracts referring to the differing developmental needs of practitioners at different phases of their experience, as illustrated by this statement by the clinical psychology supervisor:

9312: *[With trainees you need to] supervise very closely, and give direction. Which I think there is more scope for when you're training someone, when you're specifically training someone. Um, but in, but when I've worked with qualified practitioners, in each and every case, I think, I have felt I don't, they don't need that from me.*

For this reason, this section of the analysis will be structured around a proposed taxonomy derived directly from the participant transcripts and summarised in tabular form at the start. This will be followed by a more detailed analysis of individual extracts. These extensive extracts demonstrate the participants' comprehensive compliance with the discourse of *supervision as development* to which remarkable little resistance is shown. As indicated in the discursive frame chapter, there are a variety of perspectives in the literature about the developmental role of supervision

and producing a taxonomy of this sort is contestable, as will be explored in the discussion chapter.

Phase of development of supervisee	Issues for supervision
2a In training	2a (i) Assessment
	2a (ii) Safeguarding and boundaries
	2a (iii) Advice-giving
	2a (iv) Modelling
2b Newly qualified	2b (i) Managing risk
	2b (ii) Systems and processes
2c Gaining experience	2c (i) Reflecting on cases in depth
	2c (ii) From structure to autonomy
	2c (iii) Increased self-awareness
	2c (iv) Developing skills
	2c (v) Experiential learning
2d Experienced	2d (i) Ongoing professional duty
	2d (ii) Supervising others
	2d (iii) Involved in training and development

Table 5: Taxonomy of supervision issues relevant to stages of development

2a In Training

2a (i) Assessment

The close relationship between supervision as development and the training of the supervisee can cause conflicts of interest within supervision, though not explicitly recognised by the participants. Nonetheless, the clinical psychology supervisor explained the way in which supervisors will supervise trainees on placement as well as those already qualified. These supervisors have a role in the assessment of the trainee:

2798: And they can fail the placement if you really have substantial worries about their performance.

Clinical psychology is unique amongst the three professions in this study in this respect. In nursing, clinical supervision is practised exclusively amongst qualified practitioners and in counselling, whilst supervision occurs to support the trainee counsellor as they accumulate the requisite number of counselling hours, this is not

normally undertaken by the same person who undertakes the assessments. There may be some exceptions to this, but they are in the minority.

2a (ii) Safeguarding and boundaries

6929: depending on the stage that development is. It can vary, but with this certificate and diploma year students, um, in sort of monitoring safe practice, if you like, yes there are areas that I've felt I've needed to go right back to my own, err, training and dig up the sort of... it's boundaries, it's boundaries.

In this extract the supervisor is implying that learning about boundaries should be, though isn't always, something that should be learned very early on. She also indicates here that her role in monitoring safe practice is heightened when working with less experienced supervisees. This aspect is explored in detail in the later section, which explores the discourse of *supervision as safeguard* on page 170, but suffice to say here that assumptions around the supervisor's monitoring role raise a number of issues, particularly in relation to the way in which this may conflict with other assumptions about supervision, not least the developmental ones. Where a monitoring role exists, how honest can an inexperienced practitioner be about potentially unsafe practice and, by implication, how might this then restrict or inhibit their capacity to make use of supervision to develop and learn from that practice?

In the same way as a safeguarding role may conflict with the developmental role of supervision, this assessment role has the potential to cause conflicts. Can a trainee make the best use of supervision if s/he knows that disclosure of mistakes may lead to failure of the placement? This is an example of the consequences of distinct discourses being conflated in supervision.

2a (iii) Advice-Giving

2689: what trainees also have a desperate need for is... "Am I doing it right with this case"? So they will tell you in detail about a case and they desperately need feedback on, you know, "How am I doing" and, you know, and... and often explicitly, "What do I do next?"

2a (iv) Modelling

6672: you do some... get involved in some training or some workshops, and you start to actually offer back something of what you've... you've learnt in some... some shape or form. But certainly you will be modelling it in the way you work yourself and that will be noticed.

The monitoring, assessment and advice-giving role assumed by the supervisor in these extracts accords a significant level of power to the supervisor. In a training context, where a supervisee rarely has a choice of supervisor, the way the supervisor handles that power has significant implications for the supervisee.

2b Newly qualified

The clinical psychology supervisee expressed appreciation for the changing kinds of supervision he had been offered during training and now, as a newly qualified practitioner:

9843: I did my first full year erm being supervised, so in my first year as a trainee with somebody who was very structured, provided a lot of structure erm and lots of solutions, which was great, it was exactly what I needed at the time.... And so I see that as very much a natural development, that's my context for seeing it and I see that as a progression in the first year of being newly qualified as well

indicating a willingness to be subject to the demands and relations of power implicit in the discourse of *supervision as development*.

2b (i) Managing risk

The clinical psychology supervisor was reflecting on the kind of content the supervisee chose to bring to the session. This is a substantial extract, including my interventions in the interview. It is included in its entirety as it is rich in detail about this supervisor's beliefs about the differing needs presented by supervisees at various phases of their development and therefore his espousal of this discourse. It is included at this point as it relates directly to his own, newly qualified, supervisee and

he discusses his needs within the wider context of those with less and more experience. 'Q' refers to me, the interviewer and 'A' to the interviewee.

2612 A *I think it's partly that [S] is just brand new, right of the training and in some ways I think it... it feels like he's... I mean he's still very much finding his feet. Still operating out of trainee mode a bit.*

A *Um... so err... what... what [S] will tend to do is come... come with a list of things that he wants to talk about and... and kind of tick them off as they go and I get very organised by that so I feel that um... that my job then is to respond in a particular way to the questions that are... or the issues that he's raising, and that feels a bit different and um... so... so... but I was aware that it would be because it would mean in... in kind of suggesting that... that myself and [S] go... go through this um... because I suspect. I know that this is what I was struck by today.*

A *I... I think it's a developmental thing. It has a lot to do with... with where he is and in relation to the work and... and so we spent quite a lot of time talking about systems and how systems work. The waiting list and people having been on the waiting list for a very long time and we're going through a process of checking to see whether those people who've waited a long time still need to be on the list or whether their needs have changed etcetera, etcetera. He's getting on with that. So he's checking up with me, you know, where we are with that, and is it okay, and if there are particular questions he's raising those.*

A *Um... and we got him to think like this for all criteria and how we prioritise work and why that feels different is that I think when... when people are more into the work you end up almost inevitably... whilst you might do a little bit of taking an overview of the case load, if that seems appropriate or helpful most of the sessions would be spent maybe talking about one or two cases in detail and... and often going right down to a particular dilemma or issue. Um... or maybe... maybe pulling back a bit and looking at the overall formulation. Um... and what I noticed today is that we did none of that at all.*

Q *Right.*

A *Um... it was almost all reflecting on the flow of work and how we organise and prioritise work and issues around the lists and waiting times. A little bit about how we response to particular kinds of referrals. And what struck me was that it seemed to be all about the boundaries. It's all about trying to position... for... for [S] it's about trying to position himself. Find where he belongs in the service and what the expectations are. Um... and that feels very legitimate, you know, his newness. Um... and...*

Q And your role in that is a responsive one... is to... is to respond this is what [S] wants to talk about so this is what... this is how the session will work.

A Yes, yes. And... and what felt a little different partially is that... that I... I don't suppose... as yet it doesn't feel as if it's, what I'm doing is going to be um... is going to be promoting a reflective process for [S] as yet. It's like, you know, it's very business like. It's about questions and... and... and some debate. It's not that... it's not that I... I think they're unhelpful or not thoughtful conversations but um... I think what I would ordinarily be doing is much more um... what are your ideas about this, what seems to you to be the most problematic thing here, err... what have you tried, what does... what seems to work, what doesn't seem to work and... and trying to get the other person to do quite a lot of the work and not be... not being the one who has all the answers. Because today it felt like I was a little bit organised into being the one who had the answers. Um...

Q It's interesting that you say I was a bit... I was organised into that. So it was... because [S] has his list and...

A Yes.

Q ...wanted to get through it you were responsive to that rather than...

A Yes and responsive to... to... to [S]'s needs I suppose. And... and... and I was... kind of respectful of... of... of what he thinks his needs are at this time. You know, that's what he thinks he wants and needs from me as a supervisor at this stage. Um... I'm happy for it to be that way. I don't want to um... impose a definition or a model of how to do supervision... at this stage anyway but I... I... I'm assuming that these are developmental issues and that they will change overtime. His needs will change overtime.

This extract identifies a process from a stage where a newly qualified practitioner needs to 'find his feet' within the service and so has a need to ask specific questions, particularly in relation to systems and processes such as those involved in managing waiting lists and where he will look to his supervisor for definite and specific answers. He expresses a belief that these changing needs are legitimate because of the supervisee's newness but goes on to identify a phase he hope will soon emerge when the supervisee will want, instead, to engage in a more reflective process in which they can discuss one or two cases in detail and take a broader view of themes emerging. His approach is to respond to his supervisee's expressed needs 'out of

respect' rather than imposing his own way of doing things, believing these will emerge with time and experience anyway. In terms of negotiating the power relations, this extract illustrates concerted efforts on the part of the supervisor to minimise his power in the relationship. In fact, the power to influence the content of the sessions is handed over to, and accepted by, the supervisee:

2616: what [S] will tend to do is come... come with a list of things that he wants to talk about and... and kind of tick them off as they go and I get very organised by that so I feel that um... that my job then is to respond in a particular way to the questions that are... or the issues that he's raising,

The supervisor's hope that the supervisee will use this powerful position to lead the relationship into new ways of functioning as he develops is also reflected in this supervisor's supervisee's interview:

10156: Now because I understand more of those [processes and procedures] and I've got more of those under my belt it's developed more into the complexities of each case, and I would predict and this is a speculation on my part that actually over the next five years perhaps what will happen is I'll bring less cases, so I'll bring one case we'll really talk about that case because almost within each case is a microcosm of other cases as well.

2b(ii) systems and processes

These extracts both support the assumption that the 'higher' levels of development are ones where reflection is emphasised over procedure and specific answers to questions. However, this supervisee expressed the view that he had more time for reflection whilst in training and less time now he was fully occupied with a full case load:

2097: I, um... began thinking about more when I was a trainee and I think, at that time, probably had more time to think about these things and try this out as well.

2c Gaining experience

2c(i) Reflecting on cases in depth

The clinical psychology supervisee recognised that, with the gaining of experience, his developmental needs would change

3264: I would expect in a way the way we use supervision now isn't the way we will be doing supervision together in six months.

Later, the same participant likens the developmental phases of supervision to similar ones in training:

9833: the way the course is run in my experience again is that in your first year you're more contained, in the second year you're given more autonomy within your placements, in the final year much more autonomy and so supervision in some ways in the final year mirrors my experience of supervision in the first year when you're qualified.

9895: that the idea is that all trainees do go through these developmental stages in a very gradual way

2c (i) From structure to autonomy

Supervisors identified the taking of responsibility and of being able to practise independently and autonomously as signs of development in their supervisees. For example the nursing supervisor comments:

4853: so I guess that was one of the reasons it was a good session because she was a, you know...taking responsibility for her own development

9778: again I feel it's kind of partly incumbent on ... as a newly qualified Psychologist anyway to show that you can work it in an autonomous way and you can be fairly independent and this post itself requires some of that, and so that means that some of those issues rather than contacting M all the time you know I use some of that in supervision, it's a ring fenced time for that, and that's what we use it for.

2c (ii) Increased self-awareness was another way in which supervisors identified that development was taking place. For example, the counselling supervisor, in the interview following the supervision session, recalled a segment of the session where she made comment to the supervisee about how she saw the supervisee's approach to a particular client:

1314: I picked that up shortly after that and I was able to offer her the bit about, um, you know her own awareness of her own feelings in the session and her openness to them. Cos she was smiling about it and how useful, you

know, that could be both to her work and to her development as I think maybe we said at the beginning. She was able to maintain this openness to her own processes.

The nursing supervisor indicated that the supervisory dialogue itself can promote interest and motivation for further development for the supervisee:

5302: it felt in the session as though she was finding a new, um, interest in learning and developing...

2c (iii) Skills development

It would seem that supervision is seen as the place to identify, articulate and reflect on skills that are being developed in practice. For example, the counselling supervisor comments to her supervisee:

6563: and again it's about, um, you know, developing skills in... in, um, actually being very clear about how you manage... you know, in your practice about how you manage an ending.

And the clinical psychology supervisor in a later interview:

9790: there's very much an experience of growth each time, just as a therapist myself but also as a clinical psychologist as well.

2c (iv) Relationship to experiential learning

By identifying the relationship between knowledge and experience, supervisors were implicitly embracing the role of supervision as a mode for experiential learning and there are examples of their belief that the process of supervision can bring these together and therefore promote development:

6054: that's at this stage in your development as a... as a counsellor, that's good to be picking it up... and what you're gaining now is experience..., you know, if you come across similar situations in the future.

and later in the same session:

6635: you've seen something, and that's... that's learning, that's growing, that's developing and that's really good. It's great stuff. Um, and it's all experience.

and in the interview following the session she commented:

6735: I think she uses her core conditions and she uses her approach very ably. Maybe, err, that at this stage in her career, lacks some experience.

There are numerous examples in the data of participants aligning themselves with these assumptions. For example, the counselling supervisee, using characteristically counselling terminology stated in one interview:

13682: So although that is about client work it is about your personal development. And it is making you think about, yeah why did that trigger that in me? And it often makes me go away and think about things and I often will come back and say, yeah I really thought about that and I've realised that it triggered so and so in me.

An uncritical acceptance of the central place of reflection and reflective practice in supervision is problematic, not least because of its implications in terms of the requirement it places in the supervisee to be honest, and to provide access to his/her own internal processes to the supervisor. This is a key theme addressed in the discussion chapter. No resistance to this potential hegemony is expressed by the participants. But it may be that there is considerable self-monitoring going on in terms of what they choose to say and what they choose not to say in the supervisory encounter.

Assumptions about the definition of teaching were apparent. Common sense notions of teaching as the passing on of information were evident in the way in which the counselling supervisor, for example, distinguished between 'leading and modelling' and 'teaching':

6976: I've every confidence in my own practice, um, and my own, um, development, but my ability... I can see the leading and the modelling, but the actual teaching, it seems another step somehow.

2d Experienced

2d (i) Development is an ongoing professional duty

The assumption that development is a professional activity, even duty, is reflected in a number of ways, including comments on the supervisor's own development needs

and the idea that supervising others is, in itself, part of the professional developmental journey. For example the clinical psychology supervisor was particularly aware of the influence of his own supervisor both on his own development and on his supervisory style:

3071: I'm supervised by the woman who trained me in a sense. So an ongoing longstanding relationship with a supervisor that I first met[inaudible] Um... and I just, you know, I like her enormously. I admire her err... the way she works still. You know, it stills feels like I... I... I've developed hugely in that time I think, you know, in terms of my confidence, my understanding of theory um... my... my competence as a practitioner and yet she still seems way ahead. I never seem to have caught up with her. Um... and that feels really good. You know, I... because it's I guess I haven't outgrown her... so that's maybe where I get some of my sense of... of... the maturing and development of the um... supervisory relationship from.... I think she's taught me more about how to do therapy than I learned from any of my clinical psychologist professors.

3066: I don't think I've read very much on the practice of systemic supervision, but what I... what I've done I think is to um... take the foundations of um... systemic ideas and to use them in my supervision with people What I think is more... is more and more important the models that I've had when being supervised.

Development as an ongoing responsibility, with changing needs was recognised by the clinical psychology supervisee:

9709: I would hope in good Therapists that they're developing all the time and haven't reached a set point, and that's how M makes me feel as well, there are shifting sands all the time, we need to negotiate, we need to think all the time, we need to stay flexible and aware you know... And I don't see that progression being much different for the next few years either. I see it as a continued process, what I do see that's different is that I'll begin to do supervision myself now, so I'll begin to supervise others.

2d (ii) Supervising others

Training in supervision was identified by the counselling supervisor as

1180: what I needed at that point in my professional development

and the provision of supervision forms part of the ongoing developmental process for the supervisor is identify in a number of places. For example, the counselling supervisor comments in the second interview:

6851: So I think that was the sort of, um, the enormity of the developmental bit probably in that one session to be able to look back and think about my model of supervision and what elements were there and what weren't.

This supervisor's attitude towards her own training in preparation to provide supervision was beautifully summed up by her in an interview:

1200: I suppose I've been out and I've done the shopping and it's all in the store cupboard.

2d (iii) Involved in training and supervisor development

It was the counselling supervisor who reflected most on her own needs and development as a supervisor, though with some ambivalence as she discussed the apparently never-ending staging posts of training and accreditation. This is explored in more depth in the section on 'supervision as guardian', so just a short example is included here:

6996: it's the individuals who take the supervision a stage further. Um, you know, who are running and are teaching the diploma courses maybe, err, and running their own private practices and writing, um, and being published. You know, it's that.

3. Changing supervisor (as development)

Given that all the participants accepted the notion of supervision as development, they were able to reflect on whether this meant that a day would come when they might 'outgrow' their supervisor and need a different one. This would certainly be consistent with a linear developmental model, and one which focused particularly on a 'modelling' model of supervision (Rapp 2002). The clinical psychology supervisee makes the following comment:

3620: If my career goes in such a way that I begin to specialise more and more in neuropsychology, which is a bit of a specialist church, if you like, of psychology, then for those more specialist cases I might seek supervision with more specialist supervisors

which suggests that he sees an aspect of supervision as being of the passing on of expertise and knowledge from the more to the less experienced practitioner.

However, this comment comes within a wider comment about his eagerness to remain with his current supervisor:

3620: broadly yes, I would certainly be happy to have M as my supervisor in years to come. If my career goes in such a way that I begin to specialise more and more in neuropsychology, which is a bit of a specialist church, if you like, of psychology, then for those more specialist cases I might seek supervision with more specialist supervisors. But for ... beyond that, for, um, in terms of career development, progression, personal development as well, yes, I would be very happy to have [M] as a supervisor. Very happy, yeah.

By doing this, he is clearly drawing a distinction between ‘specialist knowledge’ which might be communicated through supervision and ongoing professional development and progression for which he would like to remain with his current supervisor. A similar theme was picked up by the same participant in the interview the following year. On this occasion, he emphasises that his supervisor enables him to develop in his own way and rejects ‘modelling’ as a purpose of supervision:

9657: [My supervisor] allows me to feel like I can develop and try different things myself rather than necessarily be ... be advised to clone what they do in some way or to follow their path.

Supervisor role in enabling development through phases

That the kind of supervision offered can be adapted to suit different developmental stages of the supervisee was also reflected on by the clinical psychology supervisor:

2738: you only develop from the position you currently hold so I'm... that's the kind of feeling. I need to get to know you [a new supervisee] and I need to get to know where you think you are right now in order, and then to know a little bit about where you're going err... in order to be able to help you get there. It's that sort of idea.

and by his supervisee:

3268: It feels like he is gently bringing me on almost, in some ways. Allowing me enough... {laughs}.. I don't want this to sound like, it is a bit like being a dog on a lead, one of those leads where it just extends out and out and out. So the dog feels as though he is having a good run around, but at the same time somebody... somebody is gently walking around the field.

Supervision can also be used as a staging post, marking out the developmental changes:

2708: he kind of needs me as a sounding board and a... a staging post and... and... and someone that can help him orientate himself that's fine. I don't

have a problem with that. Um... but I um... I... I suspect that um... that those will even change um... later on. It'll be the case stuff, when he starts to struggle because he's, you know, that he's not really in to um... therapeutic so err... that's the other thing to happen.

But a tension was expressed by the clinical psychology supervisor that, whilst he was comfortable with complexity and uncertainty, he recognised that there would be some supervisees and others, who might interpret this as a lack of skill, experience and ability. He makes some perceptive reflections on the implications of this:

2856: the conditionality of reality and so err... I'm really comfortable now with not having certainty around things. Err... so... and I treat knowledge in that sort of way that um... you know, that... that... that I see ideas as I'm... I'm really comfortable if ideas seem to conflict or to be imposing or different and get really excited about that and... and am very happy to kind of talk about one idea and... and put alongside it quite different idea and... and I don't... and I'm very comfortable with... with... with not telling people what I think they should think if you see what I mean. I just... just talking about ideas and... and... and exploring and... and looking at lots of different angles and things...in practice it means that I can be quite tentative and uncertain

2874: ... I think clinical psychologists would not generally... would not generally be comfortable because I think that they're expected to have knowledge and to be certain about things and my... my guess and observation is that they will generally try to do things so they'd try to be the expert on psychology.

2901: I worry that people experience me as... as a bit too fey, kind of not, a bit slippery, you know, kind of you... you... you go to him for advice and you come away and well he didn't give you much advice really.

3019: ... why can't I be an expert on things and just and kind of do that, you know, and it's because I don't want to...

3067: I see it as a problem in the... in the fit. i.e. other supervisors may be better working with those people likely to be made anxious by this supervisor's approach.

The relationships of power within the discourse of supervision as development: an unreliable bogus

It was the clinical psychology supervisor who expressed the most explicit views about the power relationships in relation to *supervision as development*. He found himself in something of a dilemma as he expressed his awareness of the potential power play within the supervisory relationship and his attempts to minimise them. The

consequence of these attempts was to be offering a very non-directive form of supervision, and he reflected at some length and with great clarity about the potential clash of expectations that may result. This is another lengthy excerpt, but is included as it illustrates the extent to which this supervisor is genuinely exercised about the relations of power inherent in assumptions about the 'expert knowledge' assumed to be held by the supervisor. This is a key issue picked up in the discussion chapter on page 205.

- 2805: A *I mean that, you can kind of adapt therapeutic skills and let people know when they're close to making those kinds of mistakes without... without them feeling too um... too kind of um... criticised or put down by the experience because that's what would worry them I think is that if it feels like it comes from a powerful... it gets into a power play I feel very anxious about that. I think my personal style and my therapeutic style is to want to de-emphasise the power difference as much as I can err... except in relation to things like access to knowledge and things like that.*
- A *I... I would want it acknowledged that because of experience and other opportunities that... that um... that it may well be that I... I'm, you know, in a more powerful position in relation to some knowledge and ideas but I don't want to use... I don't want to be using it in order to manipulate or cajole or... or to be in any way subversive.*
- 2822: A *I found some... some theory that really fitted with that really nicely and helped me to articulate it and to have value... and to value it. Err... because I think they were... they're... there are aspects of all of that that I've worried about. Um... you know, am I... am I... do I not... do I not have enough authority for instance to discharge some of my roles. Well I don't worry about that quite so much anymore because I think it is possible to be effective in other ways um... and I still... I still think there are probably ways in which it would be more effective or I could be more effective if I could behave more... in a more authoritative way but I don't lose sleep over it now.*
- 2836: A *You know I think if people are doing things because they think they ought to and because you told them to or because they think that because you do it they should do it, whatever the, you know, however it gets translated I think the... the... I think it's a kind of... it's an unreliable bogus source of why you should change or motivation to change.*

The substantial challenge facing supervisors in drawing from the discourse of *supervision as development* is for them to find ways in which they can enable and

facilitate development appropriate to the differing phases of development of their supervisees whilst modelling an approach which is consistent with the aspirations of the higher levels of the developmental phases: an autonomous, self-aware, reflective and purposeful practitioner. Whilst these aspirations themselves are problematic, both in terms of the self-subjugation required in developing reflection through supervision (as suggested above and explored in the discussion), and in terms of the conflicts inherent in espousing notions of the autonomous professional in a culture of governmentality and managerialism. These issues are also explored in detail in the discussion.

Summary of rules governing the discourse of supervision as development

1. Proctor's functions of supervision (Proctor 1987) are an accepted norm and so do not need questioning
2. Supervision requires different kinds of activity according to the developmental level of the supervisee
3. It's important to be clear that supervision does not have a role in assessment, which distinguishes it from trainee supervision
4. It's ok to need different things from supervision with increasing experience, but this should be towards increased autonomy and responsibility and away from dependency on the supervisor
5. Development, learning and reflective practice are 'good things' and personal challenges must be related to these processes, rather than to anything more 'therapeutic'
6. Development is an ongoing professional duty, as is engaging in reflection
7. In some professions at least, experienced practitioners are expected to hold 'specialist knowledge' which carries with it significant power. However, this

can be subverted by the beliefs held about the supervisory role and purpose
and power relationships can be renegotiated

Supervision as Safeguard

Discursive formation	aspects	Contingent aspects
Supervision as safeguard	1. Protecting the public	
	2. Safeguarding what is 'right'	
	3. Managing risk	3a To the client 3b To the supervisor 3c To the supervisee 3d To the organisation 3e To others
	4. Safeguarding the client	
	5. Safeguarding the supervisee	
	6. Safeguarding the profession	6a Special knowledge 6b Gate keeping 6c Professional identity

Table 6 summary of aspects contained within the discourse of supervision as safeguard

1. Protecting the public

The previous chapter outlined some important historical roots in terms of assumptions around the need to safeguard the public from people with mental 'illness'. However, interestingly, this aspect of safeguarding was not prioritised by any of the participants in this study. They expressed concern about safeguarding, but only to the extent of safeguarding the client/patient, not the wider public, as indicated in these enlightening comments by the clinical psychology supervisor:

9348: Protection is interesting. I, I, you know, being, that, um... it's interesting because its, um, it's not, it's not something I think about very much... I think about the, trying to enhance the quality of the service that people get, for instance.... And it's interesting, but I don't think of it in terms of protection because, clearly that is what we do just in terms of trying to protect them from further distress ... Um, but maybe again it just, it just comes down to being fortunate in I think the kind of relationships that I have been supervising, uh, the kind of therapeutic relationships that I have been supervising I would see as being characterised mostly, um, as being collaborative. Really focused on trying to help... So it's just funny as you asked the question, I just noticed how, how, um, how little I really think in terms of protection, if you see what I mean. It's, it's not, it's not, it's a, it's an idea that, that, that, uh, comes out of left field.

In terms of the safeguarding of *standards*, there was no talk at all of quality assurance systems of the supervisory arrangements, practice or content. Supervision *policies* existed within the mental health Trust, but the extent to which these were influential in guiding or assuring practice is debatable. There was some discussion confirming that due process was being followed in terms of safeguarding practice:

3720: (nursing supervision session): *and then we had...And then we had another course, the CPA Clinical Risk Management Course...*

though, clearly, whilst attendance at a course may increase knowledge and understanding, this does not necessarily lead to increased safeguard in practice.

Whilst the supervisors, at least, were aware of the existence of the policies, reference was only made to them within the supervisory sessions or the interviews in a qualified way. One supervisor had been involved in developing the original policy, but was himself working from his own drafts and was unfamiliar with the final draft:

10922: *But I tend to work by the one that I helped to draft rather than the one that's actually in practice. ... we tackled that issue about relationship in team management in a clinical supervision. And I identified that the clinical supervision responsibility is to help the supervisee to negotiate. But that if there was a situation where you felt that there was a need for them to do something, but they had, then they had responsibility to take that further with the single channel where appropriate*

and the other supervisor who discussed the policy was unable to locate a copy of the clinical supervision policy. Of course, these are only two individuals within a very large organisation, so no generalisations can be made, but it does indicate that their practice, at least, was drawing from *internal*, rather than *external* safeguarding mechanisms. There are clear implications here in relation to Foucault's writing on the technologies of the self and on the debate around supervision being a form of self-subjugation which is explored in detail in the discussion chapter. Suffice to say at this stage that this apparent resistance, or lack of acknowledgement, to a

discourse around external safeguarding mechanisms has implications for the value of policies for safeguarding. It brings into question how far policies and procedures actually influence practice or safeguard clients or practitioners. Is the discourse in supervision concerned with helping the supervisee identify ways of negotiating with their managers? Is this enough? The nursing supervisor likens this to power – feeling he lacks the power due to the constraints of the supervisory role and yet there is a lot of power in enabling the supervisee to negotiate for themselves: an example of the constructive nature of relationships of power.

There are examples in the transcripts of participants *recognising* a managerialist discourse but of *resisting it*. Supervisors demonstrated ingenuity in doing this. For example, in the first counselling supervision session:

62: And the other thing I want to do is, um, next time we meet, um M's asked for some sort of feedback on the client work and I'm really keen that the supervision space is confidential, but I guess we have to accept that M has responsibility for the organisation as well and that some feedback would be useful. So next session I'd like to do a review with you

Likewise, the nursing supervisor demonstrated creativity in the way he held apparently conflicting positions:

11040: it's kind of trying to hold, trying to hold the different positions in relation to the organisation. I think, I think I certainly have a different perspective on this, risk management, than I did when I was working as a practice teacher.

And later in the same interview:

11071: I think more alert to risk, but have maybe a more balanced view of it. I think the checks and balances are across the field...It's like the internal supervisor, the internal manager and internal clinician.

2. Safeguarding what is 'right'

Where a supervisor can be seen as confirming or establishing the 'right' way to practise, then a practitioner may feel there is some protection afforded to them, and to their clients. For example, in the first counselling supervision session, the

supervisee is concerned as to whether she was 'right' to hold the hand of her client, and her supervisor is suitably confident in asserting 'good practice':

193: *I mean in the main there's a debate isn't there about touch, but in the main, we are... we are away from it and we don't do it...I'm thinking you're instinct was absolutely right.*

Whilst this may feel immediately reassuring and protective of the supervisee, the extent to which the speed of this reassurance reinforces a dependency of the supervisee on the wisdom of the supervisor is arguable.

3. Managing risk

As indicated in the discursive frame chapter, working directly with clients in the field of mental health is inherently one of managing risk. The impact of this history still persists in assumptions underpinning supervision in relation to managing risk.

In the transcripts, discourse associated with risk was multi-dimensional and appeared in each domain of the supervisory relationship: risk to the client, risk to the public, risk to the organisation, risk to the supervisee and risk to the supervisor.

3a. Risk to the client

Supervisees expressed needs to safeguard their clients against risks being taking in their outside lives:

525 (counselling supervisee): the client was *taking risks*

And:

1865 (clinical psychology supervisee): *I actually think he's extremely low risk because he only makes trips [driving] that he can make...and obviously with a risk awareness kind of hat on and thinking well that's not good. Okay. Um but I think his risk can be managed clinically if you like, within... as part of the assessment, and it will be a discussion I'll be able to have with his wife as well hopefully and so, yeah I've advised him as best I can.*

The same supervisee discusses risky behaviours again in a later session:

8287: *the person themselves starts engaging in behaviours that become dangerous or risky in some way, so that, you know, alcohol use increases, or they become... they start doing things, other kind of elaborate and look kind of in the old psychiatric parlance: quite hysterical...*

However, on this occasion, rather than looking at how these risks might be mitigated, the supervisor takes his own risk by suggesting that risky behaviour by the client is a way of getting attention, indeed a very efficient way of getting needs met:

8300: *Efficient as well, you know....that need actually to get it met*

but he does not explore with the supervisee whether there is a role in mitigating that risk for the client. Indeed, this supervisor actually says:

8327 ... *but in terms of what one then does about it, I think that's a real challenge. I don't know that we very successfully offer very much to people in this sort of position.*

There is an issue that could be explored further about the impact of exposing and identifying the risks and the limits of the practitioner's ability to mitigate those risks. What is the purpose of discussing the risks if not as a means to exploring possible safeguards that might be implemented? An alternative view would be that practice is complex and to try and reduce it to risk assessment and alleviation of risk reduces both the potential of the practitioner and the client themselves.

The need to safeguard the client from things going wrong *within* the clinical environment was also expressed:

3958: (nursing supervision session): *Things going wrong is relatively, err, uncommon. Um, and that you sort of leave...you risk...end up feeling, you know, fairly confident that we're doing as best we can.*

This particular extract emerged as the nursing supervisor and supervisee were discussing a complaint by relatives when a patient chose to spend long periods alone in their room and therefore was not perhaps as closely observed as s/he could be. The supervisor, who also works in the same ward, was familiar with the case and so was quickly able to reassure the supervisee:

3980: *I think you'll find this talk useful actually because it does deal with a lot of those issues.....that you're talking about, um, not least of which is sort of, you know, lis...listening to people.....so I...I think you can't go far wrong...*

On the face of it, this is a very reassuring statement for the supervisee. However, a supervisor who had no previous knowledge of the incident would not have been able to offer such reassurance so quickly and would, instead have needed to spend longer exploring the case and the potential implications and lessons to be learnt. It could be argued that this very foreknowledge might preclude further reflection and discussion by the supervisee, thereby, whilst possibly providing reassurance in this individual case, not providing the opportunity for the supervisee to identify and manage the risk themselves more effectively in future. In the interview following, the supervisee was very keen to ensure that I understood that the client was not at risk, and yet it could be inferred that this eagerness itself reveals a certain anxiety which is has not been entirely resolved.

5592: *Yes, obviously if I felt maybe that, you know ... not that the client's at risk, she's not at risk, I'm not saying she's at risk, but obviously if I felt that I couldn't nurse her or maybe have some knowledge how to nurse her maybe in a different ... obviously we do have team talk and we obviously do openly talk genuinely through you know sometimes how people do make you feel, but, er, I suppose that gives at that time an opportunity that you can go in there and sort of like unload a little bit of how you feel.*

3b. Risk to the supervisor

2755 (Clinical psychology supervisor): *I suppose that's the risk when you're giving away the agenda of the supervision and responding to what somebody brings. The risk is that then something's called from you which you don't necessarily choose*

This supervisor is expressing the risk associated with attempting to devolve power within the supervisory relationship: that in surrendering power to the supervisee to decide what can and cannot be spoken about, consequent powerlessness leaves the supervisor vulnerable.

3c. Risk to the supervisee

7379 (counselling supervisor interview): *I sometimes think of it as it's a bit like, um, letting your friend come out of the toilets with their skirt still tucked in their pants*

This delightful comment from the counselling supervisor represents very graphically the potentially conflicting responsibilities that a supervisor holds within an organisation. Through this imagery, this supervisor draws from the discourse of supervision as safeguard in the domain safeguarding the supervisee. In order to protect her, at least from embarrassment, if not from action being taken against her within the organisation, this supervisor is expressing that she would want to negotiate with the supervisee themselves and let her know that there is something amiss before approaching the organisation. Nonetheless, in order to safeguard the client, there may have to be an occasion when this would happen. Likening your supervisee to a friend could also reveal a level of care and protection which goes beyond the purely functional.

3d. Risk to the organisation

Confidentiality is a core principle of much practice in mental health as well as in the supervisory relationship. It was the counselling partnership that discussed this most explicitly, though not exclusively. The notion of 'breaking' confidentiality is seen very much as a last resort, but there was acceptance that potential needs to exist for that to happen in order to safeguard the client as well as the organisation. This is evidenced in the section above, where the counselling supervisor appears to have some clear guidelines to her own practice in terms of behaving 'diplomatically':

7387: *It's one of the hardest bits to negotiate, probably, to retain the confidence and the goodwill of the person that you feel, you know, something needs to be said. Um, and yet, it's holding the three corners of, you know, the sheet of the contract, isn't it? You want to hold onto the supervisee and hopefully keep them onboard and enable them to learn from the experience and move on in a positive way but, at the same time, the organisation has responsibilities. I have a responsibility to the organisation to let them know if*

there's something, you know, they need to know from me and the counsellor first, rather than from somewhere else.

An illuminating extract from the nursing supervision sessions reveals a further layer of risk and raises a number of questions in respect of the place and role of supervision in identifying and managing risks within the organisation. The example relates to concerns about a colleague's practice and whether or not it constitutes lack of fitness to practise (though that is not a phrase used by the participants):

10757 (nursing supervision session): *Um, but if I say to him [the colleague about whom the supervisee has concerns], "Oh yeah, you know, you're doing fine." ... That's not helpful and I feel that I'm sort of putting my clients at risk.*

Supervisor: Hmm. There's no case for saying you're doing fine, I don't think.

In this example, where the supervisor is from the same organisation, he happened to know the person being discussed and also used to supervise this colleague's manager.

10909: *Supervising somebody with a supervisory responsibility for him, I could go into all of the things, risk, competence, and things like that. 'We went through a huge process of, um, myself, that person and a team leader, kind of I knew the team leader as well but we didn't ever actually get to discuss it, just in a very brief sense. Um, but, er, in negotiating a supervisor, supporting my supervisee to try and negotiate how to deal with this kind of undertaking and how to hand it on to her manager, and, er, I was shocked when he came back into the system, because he clearly isn't functioning.*

This raises a very important issue in terms of the conflict of interests between the discourse of *supervision as safeguard* (in this case safeguarding the organisation and/or the client) and the discourse of *supervision as containment* and *as development*. Trying to reconcile these conflicts results in some convoluted explanations, which are not entirely satisfactory.

3e. Risk to others

One of the cases discussed in a counselling supervision session related to the potential of the client to become involved in an assisted suicide. Neither the supervisor nor supervisee had come across this before. In fact, the topic was

introduced by the supervisee in the session prior to the recorded session but, as the supervisor had no experience of this, she had gone away to reflect on it and it was she who introduced the topic into the subsequent (recorded) session:

11873 (counselling supervisor): *I mean, it's this assessment of risk, isn't it? And if you feel that, um, somebody is going to harm somebody else, then you... you would have to go to the police.*

Supervisee: *So you would have gone to the police and not his GP?*

Supervisor: *No, because it's a criminal act, isn't it? So it would have been the police.*

Supervisee: *Yeah. But in a way, it's... it's...*

Supervisor: *But... but... but that's the final... You know, that's after you've explored how he feels once you've restated the confidentiality and that you could... you have wider responsibilities and you might need to break it if you do and how does that feel, and why is it the only option? You see, you've got... there's a lot before you get there.*

4. Safeguarding the client

13827 (counselling supervisee): *I don't see it as a get out of jail card. I don't ... the fact that it would be G's last resort to actually break confidentiality and maybe go elsewhere, I don't see that as a safety net.... I see it as, um ... as kind of maybe a, um, governing body if you like. That she's keeping check on me and if I did do something that was really unethical then she would have every right to do that because then I shouldn't be practising.*

This is a really interesting piece of reflection by the counselling supervisee; it is not easy to unpick the distinction she makes between her supervisor acting as a safety net, which she clearly reacted quite strongly against, and her supervisor as being some kind of governing body and is a further example of the way in which these practitioners try to reconcile conflicting discourses, in this case the discourse of *supervision as containment* (the safety net) and the discourse of *supervision as safeguard* (the governing body).

This contrasts with the clinical psychology supervisor, who expressed mild concern that perhaps he was not protective enough of his supervisee concerned enough about the risks associated with his supervisees' practice:

9298: *Mm. I, I wouldn't, I, I don't, I don't pretend that there aren't times when I worry about that I don't worry enough, if you see what I mean, uh, that I don't pay enough attention to it [protecting patients]... Yeah, should I be*

paying more attention to issues like that? Um, the reason, the reason I think I don't is because again I think, I think I've been pretty good at, at not entering, entering into a supervisory relationship with people I don't trust.

This supervisor has stumbled across one strategy for reducing potential anxiety about safeguarding clients and that is carefully to select supervisees that appear trustworthy.

5. Safeguarding the supervisee

865: And the word that comes to mind is the mother. I feel quite, um, um, not responsible, not protective but I feel like, uh ... Is it respon ... I feel like they're mine. Um, they're like ... In a sense it's like they're my children and I want the best for them.

This analogy to parenthood appears to draw from the Winnicottian notion of the 'good enough parent', inherent in the discourse of *containment* rather than from the discourse of *safeguard* and yet expresses a very protective attitude towards the supervisee, so is in that sense interested in safeguarding her.

6. Safeguarding the profession

Supervision can be seen as the forum within which those distinctive attributes of a specific profession can be demonstrated, modelled and protected, reminiscent of an apprenticeship model. In order for supervision to protect these functions within a confidential and potentially long term interpersonal relationship, agreed sets of boundaries need to be established. Often unspoken, these boundaries enable the supervisor to retain a professional stature and identity. For example, the clinical psychology supervisee reflects on the appropriate boundaries of the supervisor relationship:

3518: I suppose you could flip it on its back and say there is no need for me to find out.... [M], as my supervisor, his family structure, or to find out where he lives or what he does in his spare time... Supervision seems to be a ring fenced time where we have a space to talk about work related issues....

And he continues

3530: ... certainly recognised between the two of us, an unspoken rule if you like. And that seems to be my experience throughout as well. It would just seem inappropriate.

On further reflection, he identifies elements within his training where these unspoken rules may first have become established:

3532: Perhaps that is one thing that I have picked up from training and that session on supervision as well. I think... So boundaries more widely, and I think by talking to peers, we probably came to some consensus view, as well as taking the BPS [British Psychological Society] code of conduct, and all these other things into account, as to where you position yourself in the relationship with your supervisor. And I think that once you begin to think about those issues, you set your ground rules very firmly in a way, very quickly....Err, in fact, actually now you remind me of it, I am pretty sure, and I don't know why these memories are coming back now,

It is clear from this extract that the roots and assumptions about boundaries within the relationship have been integrated into his practice implicitly – both through his training and through policies of his professional body. As guardians of the profession, training organisations, professional bodies and supervisors themselves have a vested interest in perpetuating these assumptions in order to maintain their representative positions.

In the same way as supervisors represent the profession, the supervisory session itself somehow comes to be identified with 'professional practice', where it is important to behave in certain (professional) ways. The nursing supervisee seems to recognise this:

4664: I look very professional with my blue folder, don't I?

This is her final comment before the close of the supervision session followed only by her revealing comment:

4666: I'll put it back in my cupboard

6a. Special knowledge

1180: It's what I needed at that point in my professional development. I'd got a lot of experience but I needed some more theoretical grounding to ... for myself to feel more confident. Um, I felt yes I could talk confidently about my

experience but I couldn't, um, underpin that with a great ... any more theory than I'd learned up to diploma level.

Here the counselling supervisor reflects on her recent course of advanced study.

She describes this as a means by which she can develop her supervisory practice by having a clearer understanding of theory, in addition to her extensive practice. Her subsequent comments seem to reveal an assumption that ongoing development is important in maintaining credibility within the professional context and that those supervisors worthy of admiration are ones who can combine theory, practice and the ability to teach, and refers back to the discourse of *supervision as development*:

6969: The people I admire in my profession, um, are the colleagues who stand up in workshops – they're not the only people I admire, but people I have a lot... I maybe, in some ways, aspire to; I'll maybe not ever get there. I wondered what it was that I didn't have in my practice, and then what I realised in doing this work it is that teaching element. And it's people that have a background in education and teaching that then... and also the therapy and the supervision and the counselling background, and I think it's great to not only do it, but to also be able to teach it. I've every confidence in my own practice, um, and my own, um, development, but my ability... I can see the leading and the modelling, but the actual teaching, it seems another step somehow.

6993: Um, so, I mean that's all going along very well. I'm getting a lot of experience and I've gained a lot of confidence through the masters degree and am now using that in practice. That sort of has a nice... that's sort of progressing.

But the pressure for more training and accreditation is becoming apparent:

6996 But, yeah, I think if I wanted to, and I don't want to at the moment because I've been doing something for the last ten years and I am going to stop, but I was thinking, well, that will be it, you know, a sort of masters degree and surely that's it. No, no, no, no, I've got this supervisor accreditation. Oh, is it never ending? And I thought, well, it will. It's got to end there and then somebody said to me, "Oh, you could do trainer accreditation", and I'm thinking, no..... But, you know, my heart sank because I know that is the bit that, you know, would round me off some more. It's the bit that maybe would help me, err, deliver what I'm trying to deliver in a much more, you know, an even more, um, supervisory friendly way.... I don't know. I think what would be useful is, um, I don't know what... I have no idea what training accreditation is, or what you'd have to do to do it. Um but I suppose it is that ability to, err, stand in front of a group and teach, I suppose. And I'm not a trained teacher. Err, I'm a facilitator and, you know, counselling is about...supervising is about empowering. Um, but to actually teach is not what I've ever...I've never learnt about that. Um, now I find myself doing it and I find myself, um, you know, in group supervision I find myself pulling threads together and offering an understanding or a theory or a concept to try

and make sense of what's going on in a group. ...Err, I find myself having to stand up and deliver stuff....it's not something that I'm... it's the bit I'm least experienced in I guess and Yeah. Um, so yeah, but that's my experience, um, not teaching. And I think, you know, err, I mean whether it's just my perception but when I see... I mean, it's the individuals who take the supervision a stage further. Um, you know, who are running and are teaching the diploma courses maybe, err, and running their own private practices and writing, um, and being published. You know, it's that.

The extent to which the ongoing provision and pursuance of training and development and the apparently never-ending opportunity for greater and greater levels of accreditation genuinely contribute to the provision of a better service is arguable. It cannot go unnoticed that this very assumption provides a perpetual stream of learners, trainees and applicants for accreditation; a process which by very definition, provides the context, personnel and purpose for the existence of professional bodies to oversee their guardianship role: as long as there is more training and development needed, the more the profession can produce products, retain control and keep some in and others out. It can also maintain an essential professional hierarchy as fewer and fewer reach the higher levels:

Later in the same interview:

7472: Because I have always seen myself as an independent practitioner and I have developed my practice and I have, um, maintained my professional qualifications, insurance and development for myself, and I have gone out and, um, been employed or, um, worked in private practice using my skills. I see myself as a practitioner and I've, you know, worked in this way for A and I work in this way for AC and I work in this way as a private practitioner, but I maintain the core. And in that core is my supervision, um, and it's nobody else's business in a sense, I feel.

It is certainly arguable how far the assertion that it's nobody else's business can ever be genuinely true, but it does express resistance to a discourse imposed by the profession and the contingent sense of the 'moral' duty of the professional to a commitment to ongoing development. The supervisor's long reflection above reveals a conflict. Whilst there are clear pressures from the profession to comply, conform and develop, there is also a value of autonomy as a professional. This is

also reflected in the supervisor's assertion that she would always seek and need supervision. These conflicting discourses around the nature and role of the 'professional' are explored in the discussion.

6b. Gatekeepers

Supervisors have been traditionally seen as the gatekeepers of psychotherapy and as such were given considerable control and set on a pedestal

(Salvendy 1993 p365)

As the quote from Salvendy suggests above, there is a sense that a supervisor has some role in preventing unsuitable practitioners from entering, or continuing within, the profession. In clinical psychology in particular, supervisors play a substantial role in monitoring and assessing students in practice, and as such, are expected to identify those causing concern, as the clinical psychology supervisor explained:

2786: I'm very well aware that it's a very important consideration in the context of err... particularly for trainees where err... potentially the issue, the whole issue is should they be in the profession is... is kind of always around. I have to say I've never, well on one. My very first, the very first person I ever supervised was the only trainee and I've... I've supervised more than twenty err clinical psychology trainees, and only on that one occasion did I have any thing like a substantive concern that the person was struggling in such a way that I... I really wasn't sure that they were going to make it, or that they should make it... And they can fail the placement if you really have substantial worries about their performance. Um... and it's because of the... the way we select the clinical psychology trainees. They're... they're high selected and generally they're extremely good so it doesn't arise um... in a substantive way. It's more about, you know, I think, do they make mistakes? Are they err... behaving in ways that seem to be crossing boundaries? Do you need to kind of pull back from? Are they confused about um... boundary issues? That sort of thing.

In one or two extracts it is possible to identify a resistance to the professional assumptions around the role of the supervisor in representing and mentoring the supervisee into the profession. The clinical psychology supervisor, when asked to reflect on the influences on his practice of supervision, was able to identify an apparent conflict here:

3087: Which is very interesting, you know, actually because I... I do value. I very much value my professional background. Um... and its knowledge base,

but I don't think it taught me much about how to do therapy. That's come from the systemic therapeutic training and the supervision. You know, I think... I think she's [supervisor, a systems therapist] taught me more about how to do therapy than I learned from any of my clinical psychologist professors.

6c. Developing professional identity

One of the functions of the discourse of *supervision as guardian* is to provide the opportunity for a fledgling practitioner to develop their professional identity and so be inculcated into their professional norms. The counselling supervisee clearly found pleasure in identifying herself in this way:

6640: Yeah, it's nice being a counsellor. Like I think nice. I know I'm running out of time, but just to say it is nice.

This introduces an exchange between the supervisor and supervisee about how the supervisee identifies herself as a qualified counsellor in contrast to others doing a similar role with whom she works. She finds herself observing what she would consider bad practice in terms of the counselling values etc. For example:

6642: I think, because now I've started that new job and I think these people that I'm working with, they're not like me. And I know nobody... you know, everyone's different, everyone's unique, but what I feel they're like... it's like because I know myself so well and I've had this counselling experience and... that these new people, it's like they're really artificial.

She is struggling with competing values here: she recognises that everyone is different, but her new-found professional identity impresses on her that counsellors should behave in a certain way.

6650: but these aren't like the... these are like the new people that have started with me and it just feels like.... because we're not employed as counsellors, just ... on the telephone. But it's like we're... because this is my first job back since counselling and I've been surrounded by people that are counsellors...

6654 [supervisor]: They all think like you...trained like you.

The supervisor's response to this conflict experienced by the supervisee is to reinforce the special position that being a member of the profession confers:

6666: I guess it's about what you now have to offer other workers, not only your clients, but in terms of how you model in the work that you do. You know, you as a professional offering a professional service, and your... you know,

your degree of awareness is, err, greater. That's what you're saying isn't it, or seem to be saying, and how do I actually manage that beneficially for the group that I work in?

As the counselling supervisor indicated to me in our first interview:

1116: And it's been really hard to hold the core of the work, my work, my professional ability to work within this ever changing world that goes on around me.

In using the word 'professional' in this context, the counselling supervisor clearly draws from the guardianship discourse in espousing a belief in a set of distinct attributes that comprise her professional work, the 'core' of her work. And she believes this very core to be under threat by external and fast-moving changes.

This 'changing world' is also reflected in one of the clinical psychology supervision sessions where there is some discussion of new Trust guidance on writing case notes:

8902: Do you think it avoids... it misses the point of the fluidity of formulation. You know, this last entry here, "be professional", um, "all entries to the health and social care record must be professional opinions with rationale or evidence". We're hypothesis testing all the time.

Here, the clinical psychology supervisee is identifying a conflict between espoused notions of the work and the need to fit managerial, organisational requirements. The organisation's use of the word 'professional' is particularly significant as it alludes to the practitioner's sense of professionalism and has the potential to engender a fear that to not follow the guideline will, in some way, be *un*professional: a moral imperative.

In an earlier supervision session between these same two participants (clinical psychology) there takes place a discussion about appropriate responses to referrals made by doctors, as the supervisee summarises the requests made by two specific doctors as an example:

1722: could you go and see this person quite quickly because that would help

The supervisor reflects:

1728: if what we're going to say is that we are going to prioritise those... those kinds of referrals, then... then we want to be making sure that we're doing them in a consistent way, and make that explicit in terms of policy, so that we can point to it and defend it if an issue ever arises on that

It could be that this concern relates to the need to offer a fair and equitable service to all clients in the face of a potentially overwhelming demand, as suggested by the supervisor:

1759: that's all we do, just respond to crises, get crisis response and [7.00 inaudible] service.... We don't do anything very much in terms of, you know, therapy longer term. I don't think, I don't know, we're at that stage yet... there is a kind of an approach avoidance in things, whereby you... you worry about having too... too open a door because you're going to get, you know, a bit overwhelmed seeing... you know, you keep a bit of a distance. So I think we've just got to be aware that if we do establish better working relationships for instance, we'll then end up having to think about how we continue to be involved with them the way that doesn't then adversely affect too much the other work we do.

But this shared concern may also have a more fundamental basis: to what extent should the clinical psychologists be taking orders from the medical professionals?

As the supervisee goes on to say:

1739: I just wanted to get a sense for ourselves whether that feels comfortable or we err... you know, whether we try to resist that...

Perhaps the most powerful indication of a perceived threat to the profession came in the final interview with the clinical psychology supervisor, in which he expressed genuine concern about threats to his profession:

9382: I think there are myths that exist about psychologists, and then there are myths that exist in the minds of psychologists about the myths that other people hold ...you know one of our myths is that we're kind of, uh, viewed as... remote, ivory towered, things like that. Um... I think that, I think that we've never been anxious about that before. Um, I think maybe we didn't mind so much... about that. And now I think we feel very vulnerable.

These comments suggest that the discourse around guardianship is under threat and commitment to one's professional identity, which has worked in their favour in the

past, by guarding the status of the 'special knowledge' held by the clinical psychology profession, now comes into conflict with a newer, *managerialist discourse* in which questions are asked about whether others may be able to undertake similar tasks much more cheaply (as in the Improving Access to Psychological Therapies (IAPT) initiative). The question that then arises for the psychologists is to what extent they should start to make public their 'special knowledge' in order to maintain their status and guardianship of the profession, as to do so would also remove the protection of that knowledge. His reflections are included here in full as they represent an extremely perceptive, rich and poignant perspective on both his attachment to his profession and his dismay at its prospects for the future:

9393: I think we feel... suddenly far too invisible... to be good, for it to be a good thing... in the current climate. Um, and we also feel very expensive... But I think I would always have defended myself and said, and said to myself, there isn't anyone else doing the work that we do. And the work that we do is central to these services... But in the end, um, the, the quality of the therapeutic... um, of, of the therapeutic is what's most important with these services.... But the way things are, have changed suddenly, I think, I, I feel almost as if I've been terribly naïve and that, um, in time to come, what we do will be seen as... not just marginal but I think... not even, not even relevant... any more to public services, to public mental health services. .. And that we will be floated off, you know. I think there'll still be, there'll still be work to do and I think the needs of people will remain the same.... I think that we've, we've got to a point where... uh, in, in, in terms of the values of the society, and the way it apportions value to things like wellbeing... They [other professional groups such as community psychiatric nurses] will compete with us and they'll, and they'll, um, and I think that there will be opportunities, there are opportunities for the other professions, um, to, well to compete with us... The whole, the whole thing about secrecy is very interesting. I think that, uh... whatever one, what, you know, whatever one thinks about, uh, there, there are legitimate arguments about the way that it lends itself to being researched in the open spaces [inaudible 40:04] CBT. It's also, uh, it happens to be one of the psychotherapy trainings that pretty much deliver as a, a kind of recipe book... And, and all of that has felt like it's undermined our, our profession. And that we're being, we're being outflanked... So other professions can do their twelve week course of CBT... And then they look like they're equivalent. Um, I, I, I honestly and sincerely believe they're not.. we'll still be around, we'll still train psychologists and everything, but I think, I think that, um, things like, uh, the kind of pay scales and the sense, the sense of superiority that I think the profession has had in relation to other professions, and the complacency that I think it has felt in relation to what it does will all have to change. ...it would be imperious and arrogant to suggest that that might not be a good thing... I think that the pattern of work will be different in the future. You'll be, you'll be kept, uh, at a functional level.... Artisan level. Um, there won't be the, the... headroom and that might be diff... That, that is, well, I mean S was explaining to me, you know, the training structure is in psychology which I

was familiar with, but, you know, it's a long process and so people to go through all of that and then find that, you know, there's a ceiling fairly shortly afterwards... That's going to be, that's going to be tough... And it, it will mean that we won't attract the same kind of people into the profession. They will go and do other things... Because the, generally we recruit very bright, uh, amongst the brightest of the psychology graduates... There are others who work go off and work in, um, industry... banking whatever, but, um, I think we get a fair share of the really bright ones coming into the profession. But that will presumably change... Because they're not going to want to be a career grade psychologist paid in, sort of, um, average levels.... When there are bigger challenges... we've been moved out of that building, down into the town... the clearest indication that we're seen as somehow marginal... expendable, almost, being dislocated in that way.... Feels like it's a statement of value that's attached to us. It's hard, it's hard to resist seeing it in those terms... It's a... straws in the wind

Relationships of power within the discourse of supervision as safeguard

What appears to be most significant in terms of the relations of power negotiated within the discourse of *supervision as safeguard* are the creative and productive ways in which each of the participants manages the potential conflicts of the requirements inherent within this discourse as it interfaces with the requirements of the other dominant discourses. External systems and processes are used to advantage or resisted in order to practise in a way which is consistent with their values and assumptions about supervision.

Evidence of an 'internal supervisor', where a practitioner monitors and oversees his/her own practice, can be found in each of the case examples, as was evidence of an expectation of high practice standards. Implications of the processes of this internal supervisor, which serve to monitor and ensure safe practise are explored in the discussion chapter, in relation to Foucault's notions of governmentality.

Each of the three supervisors demonstrated their own unique approach in drawing from the discourse of risk, itself associated with the dominant discourse of *supervision as safeguard*. One of them realised that he exercised care in choosing

who his supervisees would be – demonstrating quite a significant level of control in having that freedom of choice. Another had a clearly worked out rationale for negotiating the responsibility for taking action onto the supervisee – a particularly difficult position for him to hold as he also holds a managerial function within the same Trust. Finally, the counselling supervisor took on a more nurturing, parental role in terms of safeguarding the client and the supervisee. None of these positions were externally imposed, though they do each reveal the tacit assumptions around the kinds of risks associated with the role and the responsibilities of the supervisor to manage them.

Professions have a vested interest in reinforcing the special and discreet nature of their disciplinary knowledge and expertise. Supervision would appear to offer a highly conducive environment to maintain and safeguard this special knowledge through its system of boundaries, confidentiality, accreditation and regulation. Whilst evidence can be seen in the transcripts of some aspiration towards further accreditation and development within the profession, notably from the counselling supervisor, there is also evidence of resistance to this discourse, not so much by what is said, but what is not said. There is noticeably little reference to profession-specific requirements or cultures. In fact, both the nursing and the psychology supervisor draw primarily from discourses outwith their own profession: from the psychoanalytic tradition in the case of the nursing supervisor and family systems thinking in the case of the psychology supervisor. As the counselling supervisor so succinctly expressed it:

7479: it's nobody else's business in a sense, I feel.

However, as the psychology supervisor so touchingly expressed in the section above, this very resistance may come back to haunt these practitioners as they fear being

'outflanked' by newer discourses promoting 'effectiveness' and 'efficiency' in the delivery of services.

Summary of rules governing the discourse of supervision as safeguard

1. Explicit reference to external policies is a low priority for supervision unless it is to discuss ways of containing/managing them suggesting a resistance to a managerialist discourse imposed by the organisation
2. Risks to clients/patients can be discussed but only at the individual level. Discussion of wider risks to the public and/or the profession are resisted or, at least, less apparent.
3. Responsibilities to the organisation can be reflected on by the supervisor but discussing them with the supervisee is also resisted.
4. Talking about one's own personal commitments and values takes precedence over talking about one's espoused professions requirements where these discourses come into conflict.
5. Whilst talk about professional and policy guidelines is appropriate in supervision, the talk should take a critical stance towards them.

Having undertaken an analysis of the three dominant discourses identified in the construction of the discursive frame, the data was further scrutinised to explore other potential discourses that were emerging that may create opportunities for new understandings to emerge. One such discourse in particular was identified: *supervision as nourishment*.

Supervision as Nourishment

Discursive formation	aspects	Contingent aspects
Supervision as nourishment	<ol style="list-style-type: none"> 1. Efficiency 2. Transfer of energy 3. Refreshment 4. Smorgasbord 5. Health benefits 	

Table 7 summary of aspects contained within the discourse of supervision as nourishment

In his article praising the way in which the counselling profession values and practises supervision, Mearns alludes to the 'nutritious nature' of supervision. By this he is referring to the:

supportive and developmental nature of counselling supervision, where the supervisee experiences the process as one which sustains him or her both emotionally and intellectually and which thereby creates an implicit challenge to future working

(Mearns 1995 p421)

This image of the nutritional value of supervision alludes to a different discourse, one in which emphasis is placed on ways in which supervision might sustain the practitioner's energy or help to prevent stress and burnout. It also carries a sense that supervision is somehow 'good for you' in terms of maintaining health and wellbeing.

Participants drew from this potential new discourse on a number of occasions. For example, in the first interview with the counselling supervisee, she considers the establishment of a good connection with her supervisor as essential for being able to benefit from the supervision and 'take something away from it', just as the body takes the nutrition and goodness from food:

1362: So I think being connected to the...to the supervisor is the first important thing, for me, that's enabled me to...to take stuff away from it.

Furthermore, this same participant expressed her experience that she carries with her the good things that she has gained from supervision and contribute to her later

work with clients - a bit like a carbohydrate that releases its benefit slowly to the body:

1590: ... they'll all stay with me. Yeah, definitely. I think also what we learned a long time ago is that when you go, when you're with your client, after you've had supervision, you're not just on your own with your client. Because you've got other in, other people and their comments. And maybe your thoughts are then, do you see what I mean, entwined with other thoughts.

So necessary is this sustaining function of supervision that she asserts:

1617: And I think it's beneficial. And I do, I think personally I would struggle, if I didn't have that.

This idea of extracting sustenance from supervision is echoed by the clinical psychology supervisee, who also attributes this to an effective working alliance.

3638 So I feel that you are more able to have good supervision if you like, quality supervision whatever that really means, and you are able to extract more, both if you are able to leave thinking that that was a worthwhile experience if you have some of the overlapping principles that you also need to develop with clients, for the therapy to take place. So I think you need a good working relationship, I think you need a good emphasis on the tasks at hand, what you need to achieve in each session, and I think you need an overall goal if you like, an overarching goal to the work. Um, and so I think that that allows for a good alliance really.

And the supervisor's role in ensuring sufficient nourishment is available was also expressed, as in this example from the counselling supervisor:

1200: I suppose I've been out and I've done the shopping and it's all in the store cupboard.

1. Efficiency

It is claimed that a healthy lifestyle enables the body to process energy efficiently and the clinical psychology supervisee valued the role of supervision as a means to work more efficiently

3209: Not only is it very containing as I have said, but it is also very efficient and at the moment, for me, that is really important. ... it seems that sometimes the workload is such that where you do two days a week you are actually always doing a little bit more than two days a week. So the more efficient I can be, the more people I can see and kind of work things out.

In a similar way and extending the metaphor, supervision was seen by the same participant as something to be made use of in the same way as a good workout at the gym:

3259: That his [supervisor's] experience isn't just a technical experience – this is how we do things, this is my experience clinically – there is also something about the way that he does supervision that gives me a lot of permission to go off on tangents but come back again to use supervision in a way that I feel ...Allowing me enough...{laughs}.. I don't want this to sound like, it is a bit like being a dog on a lead, one of those leads where it just extends out and out and out. So the dog feels as though he is having a good run around, but at the same time somebody... somebody is gently walking around the field.

And after a good workout, there is a sense of wellbeing:

3308: So, there was some specific advice there, but it seemed to be that, you know, we could work on that at different levels. So some of the conversation was about that. Err, that felt quite good.....that felt really good as well, to talk about other ways the service could go. So it felt good at simply talking to somebody who really had their finger on the pulse with that, if you like...I am always left, or usually left I should say, with a sense that there is not enough time in supervision because supervision is inherently rewarding... So you are left with this sense of well you know, it doesn't matter what I bring, they are going to have something useful to say.

The comment that his supervisor has his 'finger on the pulse' may be stretching the metaphor too far, but certainly is congruent with the suggestion here that the supervisory experience is like an effective health treatment with significant benefits to an individual's wellbeing.

All three supervisees allude to the beneficial effect of a good supervision session.

The counselling supervisee:

13897: But I always come out of supervision feeling really uplifted and feeling glad that I came because, um, I just, I find the whole thing just very, very useful... like I say, I come out of here feeling really good. Even if it's been a really hard session and I might have done, you know, might have had to have raised something quite difficult, it feels good.

The nursing supervisee also expresses the positive after-effects of an effective session, once again implicitly likening it to a good workout, but also recognising that there is, in some sense, a transfer of energy from the supervisor to the supervisee in

order for this sense of wellbeing to be achieved. There are connotations here of the kind of nutritional transfer that takes place between a baby and its nursing mother.

5498: having somebody listening, somebody to share it with, um ... I hope F never goes home feeling quite drained, obviously when he has these sessions, offloading my feelings, if that makes sense, because I sometimes think you take things home, and I sometimes think if we could all have a ten-minute session with somebody before we ... we walked out of the ward to how the shift went, so that if that makes sense ...

2. Transfer of energy

This idea of supervision as a means by which nutrition can be extracted for future benefit is also alluded to by the clinical psychology supervisee, when summarising his approach to the supervisory encounter:

9787: The theme seems to be let's talk about cases, let's talk about the variety of spread, let's talk about how we can extract information from all of those erm that can kind of help for future work as well.

In the same way that a baby moves from total dependence through weaning to feeding themselves, supervision can be seen as providing differing levels of dependency according to the maturity of the supervisee. As the clinical psychology supervisee explains:

9844: in my first year as a trainee with somebody who was very structured, provided a lot of structure erm and lots of solutions, which was great, it was exactly what I needed at the timebut I do think it's incumbent on us to make it such that we offer limited drain on resources and on supervisors' time as possible, and that we get the maximum gain from the placement as well.

And later in the same interview:

10118: it feels like supervision is a return to the days of training in some ways where erm you were able to draw upon the resources of somebody else erm and really use those to inform your own thinking.

Likewise, the counselling supervisee saw her supervisor as a 'resource':

13673: She is a resource...and if she's got something that she finds particularly useful she will give that to me.

3. Refreshment

Supervision as a means of refreshment is emphasised by the mental health nursing supervisee:

5372: and I think it's good because it keeps you refreshed in some aspects of your work.

And later in the same interview she reiterates the same experience:

5570: it's our time and I think we give a lot of our time to everybody else and it's our time just to refresh things that maybe are important to us with the situation of the ward and sometimes even in your own life, obviously how you feel as such. Just keeps everything alive of what we're meant to be doing as such

Expressing the experience that as clients and/or patients may drain the practitioner's resources, these can be replenished through the nourishing nature of supervision:

Right at the close of this session I asked this participant:

5778: If you had to say one thing that made F a good supervisor?

And her answer, albeit flippant and spontaneous:

5779: Makes a nice drink!

does, nevertheless, reveal her experience of supervision as nourishing and comforting.

4. Smorgasbord

A smorgasbord is a buffet-style meal comprising multiple dishes of various foods on a table. There were several examples in the data where supervisees described their positive experience of supervision in terms of having a range of possibilities offered to them by their supervisor from which they could choose ones which they preferred. For example, the clinical psychology supervisee in his second interview reflected on the session he had just completed with his supervisor:

9612: certainly today again M's been very good at offering erm offering some suggestions without necessarily telling me what to do....it's given me some

others areas to look at, some other things to try...M's allowed me to talk at some length extract the pertinent information he needed, offer some ... some insights of his own which have allowed me to feel a little bit less stuck that I've got some other areas I can go and try ideas with the client, but they're not necessarily techniques.

To stretch this imagery a bit further, the clinical psychology supervisee explained how he prepares for supervision by creating an agenda of items to be explored in supervision. This 'menu' of chosen items then forms the basis of the content of the supervision session:

9756: was I initially introduced to is this idea of agenda setting at the start of each session... I go in with a plan of how I think things could develop and then from there it's a moveable feast

This notion of the supervisor providing a range of possible options, buffet-style, was also expressed by the mental health nursing supervisee:

11535: I don't think he would actually give me the answers to it although there are times when ... he's ... he's quite like hanging the answers up but whether I see it or not it's kind of...

5. Health benefits

It was the counselling supervisee, in particular, who expressed the benefits to her wellbeing of simply having a place to offload the emotional pressures of working in a confidential way with clients' emotional material:

13754: But being able to actually say to G I was completely out of my depth, it was horrendous, um, and us talking about it and actually working out why it went so wrong, that's what it's about. Because I learned from that. And then I also got reassurance that yes I'd done the right thing ...

She perceived this to be such an important benefit that, when asked, she was confident that she would seek out supervision for this reason, whether or not it continued to be a requirement of her professional body:

13848: I would still have it and I would do it anyway because I couldn't ... I don't think that I could do the job that I do without that...offload all my, um, you know, my concerns and that. But then that in turn then enables me to be a better practitioner....So if you don't open up as much you're not gonna get as much benefit from ... it in terms of your own development.

Relations of power within the discourse of supervision as nourishment

If a new discourse is emerging around supervision as a place for nourishment and as an enhancement to wellbeing, then new power relations need to be negotiated. A number of questions are implied by the emergence of this discourse, including:

Is it sustainable to develop this discourse while still drawing from discourses of *containment, development and safeguarding*?

- Is it likely to reinforce a nurturing parent role in the supervisory relationship, such as would be consistent with the discourse around containment, perhaps?
- Does a focus on well-being fundamentally shift the balance of power within the supervisory relationship and require a more equal partnership, perhaps?
- And if this discourse has its roots within a wider discourse to do with healthy workplaces and new ways of working in terms of patient/client centred care, then does this necessitate a fundamental review of the ongoing place of a relationship in which the patient/client is absent though central to the conversation?

These questions will be addressed in the discussion chapter.

Summary of rules governing the discourse of supervision as nourishment

1. Supervision can be spoken of as a resource to be drawn from, possibly even as necessary as food, which makes it very difficult to talk about the possibility of managing without it.
2. Talking about the benefits of supervision to one's wellbeing is valuable, though this contrasts with a resistance to talking of it as a way of managing anxiety

Chapter eight: Discussion

Introduction

The intention of this discussion is to develop the outcomes of the analysis with reference to Foucauldian notions of power and knowledge. The aim is that by critiquing the findings through a Foucauldian lens, the opportunity is provided for new discourses to emerge which, in turn, may enable the construction of a new framework for supervision.

As described in the methodology chapter, this Foucauldian analysis of discourse is based on two assumptions; firstly that discourse, practices and organisations interact with each other in constructing a consensus as to the nature of any given concept, including supervision: it is based on the assumption that

the penetration of discourse x into organisations shapes the nature of the discourse and practices of that organisation producing a shift in its discursive structure, which then contributes to an emerging consensus
(Gilbert, Cochrane and Greenwell 2003 p791)

Secondly, it accepts Giddens' assumption that the nature of contemporary, post-traditional, society, demands the renegotiation of identities and relationships through dialogue:

traditions have to be justified against alternative possibilities rather than being taken-for-granted; that relationships in public, based automatically upon authority are in decline, as are personal relationships based upon the rights and duties of, for example, kinship; and that people's self-identity, rather than being a feature of given possibilities and roles, is reflexively built up through a process of negotiation. Relationships and identities therefore increasingly need to be negotiated through dialogue, an openness which entails greater possibilities than the fixed relationships and identities of traditional society, but also greater risks

(Giddens 1990 p139)

Each of the three dominant discourses will be discussed in turn, with reference to the literature. The focus will be on the *discursive formations* with particular reference to

the *rules* that appear to govern what was and was not spoken about and the *relations of power* that characterise the discourse (Foucault 1980), as described in the theoretical positioning chapter on page 16.

Supervision as containment

Analysis of the relations of power as they relate to *supervision as containment* suggests that there exists a tacit agreement between the players in each of the supervisory relationships. This agreement demands acquiescence from both players: the supervisor is required to be sufficiently strong in order to 'hold' the supervisee and the content of the session. The supervisee, equally, is required to assume the more dependent role of being held in order to maintain equilibrium in the relationship. Should the supervisor begin to express an unwillingness or inability to continue to take the more powerful part, or the supervisee refuse to accept their more subservient role, and resist being held, then the entire containing nature of the relationship is threatened. On first glance, it would seem that the supervisor is the more powerful member of the partnership. However, in terms of what Foucault refers to as the *micro-mechanisms of power*, it is equally beholden upon both to maintain the equilibrium. By the very nature of the way the relationship has been constructed, either member has the power to maintain or resist the balance of the relationship and so undermine the containing nature of supervision:

Power, when it is exercised through these subtle mechanisms, cannot but evolve, organise and put into circulation a knowledge, or rather apparatuses of knowledge, which are not an ideological construct

(Foucault 1980 p102)

There was some evidence of strategies being employed to avoid this threat. For example, the clinical psychology supervisor reflected on his ability to select his supervisees and the contingent power to avoid those supervisees who appeared to present more of a risk to the preferred way of working

9302: I think I've been pretty good at, at not entering, entering into a supervisory relationship with people I don't trust.

This is supported in the study referenced in the literature review (King and Wheeler 1999) where it was found that supervisors were reluctant to take on newly qualified supervisees or supervisees in whom they did not already have confidence. King and Wheeler explain this in terms of supervisors avoiding those supervisees who would be unwilling to accept the responsibility of the supervisor. In light of a more productive view of the nature of power relations, it could also be that supervisors were reluctant to take on supervisees who might resist the accepted norms. There is mutual benefit to accepting this as a norm as long as the discourse of supervision as containment remains important to the participants. There were occasional hints from the clinical psychology supervisor that this norm was not entirely acceptable to him. He spoke eloquently and at length about his anxieties over the extent to which he could influence his supervisees, and the extent to which that seemed to be expected from him:

2814: I'm, you know, in a more powerful position in relation to some knowledge and ideas but I don't want to use... I don't want to be using it in order to manipulate or cajole or... or to be in any way subversive.

This supervisor appears also to be alluding to, but resisting, the discourse of supervision as development in this statement, as he resists the positioning of himself as someone who holds 'expert knowledge' and therefore in a powerful role within the *discipline*.

Containment or therapy?

As seen in the analysis, the assumption that supervision is not, and should not be, confused with therapy was reinforced on a number of occasions:

14258: And I'm just needing to, I suppose, remind myself that this is supervision, not therapy.

This assumption is firmly reinforced by much of the supervision literature (Salvendy 1993; Yegdich 1999b).

If dealing with repeated countertransference situations would involve considerable focus on the background and dynamics of the supervisee, then personal psychotherapy is more appropriate and should be recommended
(Salvendy 1993 p364)

A further argument proposed for supporting the view that supervision is not therapy is proposed by Heath and Freshwater, who suggest that a critical reason to distinguish between the two is because therapy excludes the client (Heath and Freshwater 2000). The relationship between the client/patient and supervision is an important issue of its own and is discussed in more detail below.

Nonetheless, as outlined in the discursive frame chapter, the roots of the concept of *supervision as containment* are located within the therapeutic tradition. The literature review also identified that several formulations of supervisory styles and functions derive from therapeutic orientations. In terms of history alone, links between supervision and therapy are inseparable. Yet, explicit reference to these roots and links was not made by any of the participants. Whilst this may be simply a lack of awareness of this history, it is nonetheless significant that the discourse of supervision as containment is so accepted a norm that it no longer relies on knowledge of its theoretical roots. With the loss of historical memory, it appears that the *structure* of the concept remains but potentially valuable *purposes* may have been lost. For example, it was identified in the analysis that participants did not speak of supervision as a place to contain their *anxieties*. However, if they were able to reconnect with their history in this respect, they would realise that much of the formative thinking around notions of containment were for the very purpose of containing *anxiety* (Bion 1963), (Hughes and Pengelly 1997).

Interestingly, Hughes and Pengelly also suggest that ‘realistic agency procedures and guidelines’ may also serve a similar purpose: providing a sense of being held. They argue that anxiety can serve as a determinant/justification for procedures and guidelines. Perhaps the very instrumentalism of policies and procedures has become a substitute anxiety-management tool. This might suggest that agencies are drawing from the discourse of *supervision as safeguard* rather than *supervision as containment*. In this context, this would also explain organisational discomfort with aligning supervision to therapy, and justifies the function of external policies and procedures as a tool of containing anxiety. However, this does not entirely explain that, despite this suggestion of the holding function of policies and procedures, the only reference participants in this study made to agency procedures and guidelines was in the context of trying to manage one’s way through them, rather than as providing some sense of security or holding. If anything, anxiety was seen to be *increased* by the need to engage with these policies. This could suggest that the participants themselves preferred to draw from the *containment* rather than the *safeguard* discourse.

Despite the pervasive and strongly held assertion that supervision and therapy should be kept separate, some psychoanalytic processes continue to be promoted as relevant to supervision. Salvendy (1993), in the same paper in which he reasserts the distinction between supervision and therapy, recommends the exploration of countertransference as being integral to the ‘experiential component’ of supervision and draws support from many other writers and researchers into supervision in support of the view that:

The effectiveness of supervision depends largely on the quality of the relationship between supervisors and supervisees

(Salvendy 1993 p364)

Most significantly, Salvendy is explicit about the similarities between therapy and supervision being the way in which both environments focus on an exploration of the parallel process:

One of the most salient aspects of the parallel process is evident in the not infrequent power struggle between the patients and the therapist on one hand, and the trainee and the supervisor on the other...often the obstacles in therapy, usually centring on countertransference, will be paralleled in the supervisory process

(Salvendy 1993 p365)

The analysis highlighted occasions where participants were drawing from psychoanalytic insights such as the parallel process and unconscious processes, confirming their apparent willingness to draw from a therapeutic discourse.

Boundaries: “that lovely sort of squashiness”

Whilst the idea that supervision has ‘bouncy castle boundaries... that lovely sort of squashiness’ (transcript line 910) gives an impression of a flexible and negotiable opportunity for supervision to adapt and change according to the needs and aspirations of those involved, negotiation of where these boundaries may lie at any particular point in time is not something which the participants were able to talk about. On several occasions, it was made clear in interviews that there was an *assumed* agreement about those boundaries but that it was not something that was discussed in supervision itself:

3564: it just seems there are almost implicit boundaries that you don't cross. Um, and some of that seems common sense. I don't know if it is common sense, or if it is something that now seems common sense because it is just so regular practice

(Clinical psychology supervisee)

though participants were able to comment on these boundaries in their interviews with me:

An example from my first interview with the counselling supervisor:

879: *But I did come in and take, um ... I had ... I felt I had to take control and set some rules and, um ... You know, that we would start on time and I asked somebody to be the timekeeper. And it was important that ... that confidentiality and that we were respectful to each other's views*

And in the second recorded counselling supervision session:

6020: *...um, I guess probably that's possibly one of the... the few times that you may have been direct if someone is telling you about... is clearly saying to you, "I'm considering harming myself or threatening my own life", then I guess it's the moment to reiterate the confidentiality...*

And the second interview with the same supervisor:

7063 *I am absolutely adamant that, um, you know, the supervision space is confidential and I do not feed back to the Service Manager about, um, the Counsellor and their work, unless there are issues that need to be raised, in which case we would do that; either the Counsellor would do it or we'd do it together, or whatever we'd agreed.*

Connecting 'regular practice' with 'common sense' in this way serves to normalise the tacit agreement between the supervisor and supervisee around the lack of specification of boundaries. This *normalisation* may be seen to be an aspect of governmentality (Holmes and Gastaldo 2002) and is explored in more detail below.

Supervision as development

As has been emphasised throughout this study, one of the major problems with much supervision literature is that it insufficiently distinguishes between contexts and cultures. Arguably, *the* most significant area where this has important implications for the practice of supervision is in the persistent lack of differentiation between the North American and British contexts. This is of particular importance in relation to this aspect of *supervision as development*. As indicated in the discursive frame chapter, the roots of this aspect of supervision can be located in the (American) developmental models and were almost exclusively targeted at training environments. There exist critical differences between training environments and post-qualifying environments, including:

- the teaching role of the supervisor
- the essential role of assessment of the supervisee
- the role of the training agency
- the emphasis placed on learning, both content knowledge and professional attributes
- the role of supervision as an induction into the profession

Each of these, and other distinctives, critically shape the nature, purpose and process of supervision. Where these are uncritically applied to a post-qualifying environment, of which authors of the literature probably have no experience, the implications may be inappropriate. In this study, analysis suggests that supervisors are uncomfortable with the kind of power this seems to afford them. They do not want to be in the role of assessor or of some kind of guru who holds expert knowledge to be dispensed to grateful supervisees, as indicated in the quote from the clinical psychology supervisor above:

2814: I'm, you know, in a more powerful position in relation to some knowledge and ideas but I don't want to use... I don't want to be using it in order to manipulate or cajole or... or to be in any way subversive

The power of expert knowledge – “an unreliable bogus”

In a training environment it is probably reasonable to assume that the teacher is more experienced and possesses more knowledge than their trainee (though this cannot always be assumed to be the case). Any learner, enrolled on a course of study, would be actively seeking to receive from his/her teachers both new knowledge and skills. In supervision that takes place outwith a training environment, however, this relationship should not be assumed. In this study, both the counselling and the clinical psychology supervisors expressed anxiety about their competence as teachers. The clinical psychology supervisor in particular expressed discomfort with assumptions made about the ‘expert knowledge’ which he was supposed to hold:

2874... I think clinical psychologists would not generally... would not generally be comfortable because I think that they're expected to have

knowledge and to be certain about things and my... my guess and observation is that they will generally try to do things so they'd try to be the expert on psychology....I worry that people experience me as... as a bit too fey, kind of not, a bit slippery, you know, kind of you... you... you go to him for advice and you come away and well he didn't give you much advice really... why can't I be an expert on things and just and kind of do that, you know, and it's because I don't want to...

The place of expert knowledge and the relationship between knowledge and power is a key theme in Foucault's writing. Whilst rejecting the ideology that 'knowledge is power', he does assert that where knowledge is recognised as being held by certain *authors* within the *discipline*, then their *commentaries* (what they have to say about the subject) puts them in a powerful relationship in relation to newcomers into the discipline. It is the power based on this kind of relationship that the clinical psychology supervisor refers to as an 'unreliable bogus' (line 2840). There is a wealth of literature which explores the role of the supervisor in inducting the 'neophyte' into the skills and knowledge associated with their espoused profession (Holloway and Poulin 1995) and therefore drawing from this discourse of supervision as development. In this study, however, considerable resistance to this aspect of discourse was expressed. This resistance can also be identified in some British literature such as Epling and Cassidy's (2001) assertion that seeing the supervisor as expert can actually hinder effective supervision.

Supervision has been recognised as having a role in the continuing professional development of practitioners in each of the professions involved in this study, and others (DH 2002; BPS 2005; BACP 2007 (first published 2002)). However, only through an awareness of the history of the discourse of *supervision as development* within a training context can tacit assumptions about the developmental purposes of supervision be challenged. There is little, if any, critique of this assumed developmental potential of supervision, and very little discussion about other

potential forums that might enhance professional development at least as much, if not more, than supervision.

Supervision: a developmental journey?

Analysis of the data revealed sufficient occasions when participants related aspects of supervision as being appropriate to different stages of their own development that a tentative taxonomy was compiled (included in the analysis section on page 153).

This taxonomy, drawn solely from the words spoken by participants in the study, provides a concise formula for the supervisor and supervisee to negotiate which might be the most appropriate skills and interventions at any particular stage.

However, the extent to which this taxonomy simply reflects tacit and 'common sense' assumptions about the needs of practitioners as they become more experienced needs to be explored. Simple assumptions about a linear journey from novice to expert, based on traditional views of the education process may no longer be fit for purpose.

Not all newly qualified practitioners are the same. Some may have vast experience in related fields from which they can draw perspectives and understandings.

Similarly, an experienced practitioner may be experienced in a very limited field of practice and lack a broader contextual or cultural understanding. Theories underpinning experiential learning would suggest that adults learn best when they are able to make connections between new understandings and their own experiences. In light of this, Benner's influential conceptualisation of novice to expert (Benner 1984), therefore, needs revisiting, as suggested by Heath and Freshwater, in their analysis of the development of expert practice through clinical supervision (Heath and Freshwater 2000).

A further problem with assumptions around the discourse of *supervision as development* pertains to the tacit assumption that development should always be

towards increased autonomy and independence. This would certainly appeal to a professional discourse which seeks to reinforce the autonomy of the 'professional' and the notion of the profession/*discipline* being the guardian of its own specialist knowledge. These issues are explored in detail in the section below looking at supervision as safeguard of the profession.

Professional development through reflective practice: a moral obligation?

A further problematising of the discourse of *supervision as development* relates to the pressure to see professional development through reflective practice as a lifelong professional duty: an essentially *moral* obligation for professional practice:

For nurses not to reflect on their practice or to refuse to participate in reflective strategies of the institution may be seen as unacceptable, unprofessional and unnatural alternatives.... Once in the public domain they may be controlled by the dominant discourse, or appropriated for and by various collective movements or causes

(Cotton 2001 p514-515)

An uncritical acceptance of the discourse of *supervision as development* makes it difficult to resist this obligation without also appearing to be somehow unprofessional, and in this way, reflective practice becomes *normalised* and imbued with a moral imperative (Turner 1997; Holmes and Gestaldo 2002). Holmes and Gestaldo (2002) describe the *normalised* way of living as one which refers to conformity to a set of social rules and ways of conceiving oneself and others, suggesting that the power of normalisation imposes homogeneity by setting standards and ideals for human beings. Once a practice has become normalised in this way it carries with it considerable power.

The promotion of reflection and reflective practice is consistent with contemporary beliefs that self-fulfilment comes through self-knowledge (Turner 1997). Foucault argued that the very existence of a subjective self is a relatively recent construct,

which became possible only once the human anatomy had been successfully mapped by the new scientific disciplines and could therefore be observed (Foucault 1977). Whilst Turner doesn't refer specifically to the process of reflective practice, the implication of this 'new moral code' is a form of self-subjugation in that for a practitioner to be genuinely professional s/he has a moral duty to engage in a process which requires the development of self-awareness and self-knowledge through the externalising of internal processes.

One of the key *authors* in relation to reflective practice in clinical supervision, Chris Johns, sees reflection as a potential tool for personal growth under the direction of an 'enlightened guide' (Johns 2005). This is consistent with views expressed by other writers, also drawing from this discourse of *supervision as development*:

some involvement with self with self-awareness, acceptance of an internal locus of control and responsibility for one's own actions is at the heart of professional practice and must therefore be part of clinical supervision
(Heath and Freshwater 2000 p1299).

And there is evidence of a similar belief expressed by the counselling supervisor in this study:

1314: I picked that up shortly after that and I was able to offer her the bit about, um, you know her own awareness of her own feelings in the session and her openness to them. Cos she was smiling about it and how useful, you know, that could be both to her work and to her development as I think maybe we said at the beginning. She was able to maintain this openness to her own processes.

Johns goes further in arguing that clinical supervision is *emancipatory* (after (Habermas 1971) in the sense that it has within it the capacity to facilitate emancipatory knowledge by which the practitioner is afforded the opportunity to develop self-knowledge, rather than simply *technical* knowledge (after Habermas). He remains critical, however, in arguing that where clinical supervision is implemented by an organisational drive, it is the *technical* interests of the organisation that take precedence over any emancipatory interests of the practitioner (Johns 2001).

Johns', assumptions about the emancipatory potential of clinical supervision has been hotly contested in the literature. Rolfe and Gardner, for example, distinguish between what they describe as the 'epistemological' and the 'ontological' projects of reflection. They argue that an ontological approach – as epitomised in the writing of Johns - focuses on "personal growth under an enlightened guide" and may be seen as a "subtle and persuasive exercise of power" (Rolfe and Gardner 2006 p593), while an epistemological approach, which has its roots in the work of the learning theorists, Dewey and Kolb, is concerned "primarily with reflection as a means of accessing the personal 'practice knowledge' that each of us possesses as a result of our prior experiences" (Rolfe and Gardner 2006 p594). This epistemological approach, concerned with exploring practitioners own methods of thinking about their practice, may offer something which can be described as truly emancipatory. Their conclusion is that reflection should be used to learn about our *practice* rather than to learn about *ourselves* and that this is what will achieve the emancipatory interest to which Habermas refers (Habermas 1971).

Gilbert suggests that the emancipatory interest itself within clinical supervision is a form of the new self-surveillance and, as such, not genuinely emancipatory at all but rather part of the modern strategy of government and reinforced by the hegemony of clinical supervision asserted in nursing with its claims of emancipation and empowerment (Gilbert 2001). His claim is that it is necessary to perpetuate the concept of the 'docile body' (Foucault 1977) in order to facilitate the promulgation of technical interests and discourage resistance to it. This perspective throws into question any emancipatory interest deriving from reflective practice or clinical supervision.

Gilbert goes on to argue that Foucault's notion of the 'clinical gaze' has become a mechanism of power and the body has become as something docile that could be subject, used, transformed and improved through surveillance, as bodies have to be analysed and monitored to evaluate their functioning (Armstrong 1993; Gilbert 2001). This is relevant to this discussion as supervision, and particularly the place of reflective practice within it, has been accused of being a subtle and covert mechanism for surveillance; ideas which are explored further below.

Foucault's analysis of the 'gaze' derives from his study of the history of the penal system in which he identified the creation of Jeremy Bentham's innovative prison design of the late eighteenth century as a defining moment:



Figure 3 Bentham's Panopticon

*Attributed to Carrie Sloan
Licensed under creative commons licence: non-commercial share alike*

A central observation tower could house one prison guard, positioned to be able to observe every individual prison cell arranged around in a circle. The principle behind the design was that the individual prisoners were unable to see when and whether they were being observed at any particular time, effectively leaving the *watching* to the *watched* and so ensuring that they regulated themselves.

As Turner argues, once the body could be seen as a site of knowledge, a whole system of power relations can be effected; embodied in the day-to-day practices of the health professional, described by Turner (Turner 1997 pxii) as “a colour dye diffused through the entire social structure and embedded in daily practices”. In this way, far from being an independent agent, the ‘self’ is itself a construct that is only able to act in accordance with the way it has been conceived by the disciplines that created it.

It is only through the extended gaze ... that the psychological and social characteristics of wholeness and identity come to exist....it is ironic that having had their subjectivity fabricated those same subjects insist that subjectivity is an invariate and universal component of human life
(Armstrong 1993 p61)

So whilst the ‘gaze’ began as an external system, all that is needed for regulation is that individuals believe that the ‘gaze’ may be directed towards them. This prompts a system of internal surveillance and monitoring.

With each freedom that individuals have purportedly gained, has come accompanying panoptic techniques.... A system of layer upon layer of ‘expert’ gaze
(Cheek and Rudge 1993 p279)

This conceptualisation of the self has significant and wide-ranging implications for much professional activity and none more so than in mental health practice, where ‘observation’ itself is a longstanding activity of the mental health professional. The function of the ‘Special Observation’ of those deemed at risk to themselves or others, adds an added dimension of relevance for the role of observation (Stevenson and

Cutcliffe 2006). Not only are practitioners expected to observe themselves, through reflective practice and personal improvement they are also required to observe others. Participants in the study expressed some anxieties about this role and the related assessment of risk, using the supervisory conversation to seek reassurance.

Supervision: a confessional?

Gilbert picks up the challenge of Johns' assumptions of the emancipatory and empowering interests of reflective practice within clinical supervision. He questions whether it isn't more akin to the *meticulous rituals* of the *confessional* (Gilbert 2001), making reference to what Foucault (1981) calls an 'obligation to confess'. Cotton (2001) extends this argument with a Foucauldian analysis of the way in which the public expression of private thoughts, through the encouragement of reflective practice in clinical supervision, can be used as a means of *surveillance*.

Whilst recognising the notion that clinical supervision has the potential to constitute a form of surveillance, Clouder and Sellars (2004) convincingly counter the assumption that it is necessary confessional in nature, arguing that "individuals are always visible and always subject to surveillance as social beings, and that "professional practitioners are scrutinised by colleagues and clients whether or not reflective practice and supervision play a part in working life". These authors suggest that despite reservations, clinical supervision does offer scope for individual agency (Clouder and Sellars 2004 p267), a position borne out in the study by Begat and Severinsson (Bégat and Severinsson 2006).

It is, perhaps, after all, Rolfe and Gardner's proposition that foregrounding an *epistemological* approach to supervision, focusing on experiential learning deriving from past experiences, offers a more positive view of the role of reflective practice in clinical supervision. This retains a developmental focus to the activity. Analysis of

the rules governing the discourse around supervision as development in the previous chapter suggests that ongoing development was unquestioningly accepted as a professional duty by participants in this study and that such development should be in the direction of increased autonomy and decreased dependence on the supervisor. To what extent there was any awareness of distinctions between developing practice and developing themselves is harder to determine, though the quote at the beginning of this section suggest that the counselling supervisor, at least, understood '*openness to her own processes*' to be indicative of a positive development. This apparent lack of differentiation between personal and professional development may go some way to explain some areas that appeared to be tacitly 'off limits' in the supervisory encounter.

Supervision as safeguard

Analysis of the data identified little discourse around responsibilities of practitioners towards safeguarding the public. This initially appears surprising for a number of reasons, not least the historical connection between mental health practice and criminality (Foucault 1982) (McCallum 1997), as outlined in the analysis of the roots of the supervision as safeguard discourse in the discursive frame chapter on page 131. This history would suggest the existence of assumptions, albeit tacit ones, around the professional responsibility of practitioners to protect the public from potential risks posed by their clients/patients. Notwithstanding the fact that the data collected for this study is limited and cannot be assumed to represent the entirety of concerns of the participants, it could nonetheless seem surprising that none of the supervisors identified themselves with a role of overseeing the management of risk to the public. Foucault's insights into the ways in which power is negotiated through micro-relations and day-to-day sets of specific practices are helpful here and are used as the basis for a discussion around the interface between the (relatively) private and personal space of the individual supervisory encounter and broader,

cultural, discussions about the role of the organisation in contemporary healthcare practice. The intention is that this discussion will help to explain why, despite the apparent dominant discourse around the need to protect the public, within the small-scale interactions between supervisor and supervisee, the very act of 'not-speaking' about it becomes itself a powerful site of resistance to prevailing expectations of the organisation and wider society. It raises again the role of the 'self' and the need for 'self-subjugation' in terms of the responsibility of the professional to the wider public.

Clinical governance and Governmentality

The previous review of the discourse of the professions on page 100 identified the impact of the emergence of clinical governance on the practice of supervision (DH 1997). The relationship between forms of self-subjugation and the external imposition of these clinical governance procedures may help to explain the apparent resistance of the participants to engage in discussion of their duty to protect the public.

On the one hand, there is much evidence in the data of participants actively subjugating themselves within the supervisory relationship as a form of disciplinary accountability associated with Foucault's concept of the 'docile body', as in this example spoken by the counselling supervisee:

13831: I see it as, um ... as kind of maybe a, um, governing body if you like. That she's keeping check on me and if I did do something that was really unethical then she would have every right to do that because then I shouldn't be practising.

Whilst this example demonstrates a self-subjugation, that subjugation is to her individual supervisor only, and not to any *external* governing body. In this example, the supervisor, herself, *is* the governing body. In this respect at least, despite attempts to *normalise* the practice of clinical supervision by making a positive connection between it and clinical governance within nursing (Brocklehurst and

Walshe 1999), the very externalisation of accountability that clinical governance requires and the mistrust towards more personalised, internal systems of self-monitoring that it suggests could explain reasons behind the ongoing resistance to the implementation of clinical supervision in nursing:

Contracting, audit and quality monitoring work to discipline professional activity.... Surviving tests of mistrust produces trust and legitimates performance....professional activity becomes committed to processes of distrust in which distrust becomes institutionalised and placed reflexively with third parties – the guardians of trust

(Gilbert 2005 p574)

Within the context of an enormous, though precarious and risky, organisation such as the NHS, its various 'internal systems' can be seen each to be vying to fulfil its own particular mandate, the objective being to create an external face of a coherent, consistent and progressive organisation. However, in practice, these systems come into conflict with each other to such an extent that the individual practitioner can find him/herself seeking to meet contradictory agendas.

It seems that one way in which practitioners resolve this contradiction is to rely on their own systems of ethical practice. When external systems are imposed which seem to suggest a *mistrust* of the practitioner's ability to monitor themselves, significant resistance is shown through the small and localised micro-relations of power as represented through the supervisory relationship.

The government's strategy is to:

develop workable coalitions between general managers and leaders of the profession, thereby minimising practitioner opposition but still maintaining the principles of general management

(Sheaff, Rogers, Pickard, Marshall, Campbell, Sibbald, Halliwell and Roland 2003 p408)

This suggests that clinical governance procedures seek at once to impose external accountabilities, whilst at the same time devolving responsibility to the local level and making practitioners personally accountable for the delivery of professional practice;

thus at one and the same time establishing an environment of both mistrust and personal accountability. It is not surprising, then, that individual practitioners exert resistance to this apparent *double bind* (Bateson, Jackson, Haley and Weakland 1956). This is exquisitely demonstrated by the nursing supervisor, who interestingly held both supervisory and management responsibilities within the Trust:

10945: It's interesting and difficult to kind of, to have so little power within the system. But yet you have a lot of power to ... So the power to make something happen.

Governmentality, Managerialism and the management of risk

As outlined in the literature review on page 55, the Foucauldian concept of *Governmentality* focuses on the way in which populations can be managed without relying on coercion, but rather through the

promotion of specific norms that work to produce a sense of obligations and responsibility. These modes of moral regulation are promoted through myriad social institutions and involves the promotion of the ethic of self-management (Gilbert 2005 p569)

In parallel to this, the emergence of a new *managerialist* discourse in health, as explored in the literature review on page 100, highlighted the need to increase 'efficiency' and involved measuring economy and performance indicators, which soon came to be focused around a *quality* agenda (Harrison and Pollitt 1994). The analysis undertaken for this study suggests that these two discourses present conflicting and irreconcilable demands on practitioners, and the way they manage this is to resist the external, managerial, discourse, but to embrace the internalised, governmentality discourse.

Risk society

One of the key constituents of *governmentality* is the obligation it places on professionals to calculate and manage *risk*, drawing again from the principles of the Panopticon as described above (Petersen and Bunton 1997; Turner 1997):

the disciplinary management of society in which the principles of Bentham's Panopticon are institutionalised through everyday routines and mundane arrangements..... The carceral [imprisoned] society indicates a regime of micro-relations and disciplines which operate through a complex web of self-subjugation... As the global economy develops into a culture of risk, the nation state is forced to invest more and more in internal systems of governmentality

(Petersen and Bunton 1997 pxviii)

Turner (1997) refers to Beck's (1992) notion of the 'risk society' in describing ways in which the 1980s saw the marketisation of social relations in social services and health, through processes of managerialism, privatisation and deregulation. The risk society is one in which every individual is increasingly exposed to real, or imagined risks that are no longer boundaried in the way that perhaps they once were. Disease, for example, respects no boundaries of class or nation, and mass communication, scientific knowledge and the possibility of mass destruction have broken down any previously-held notions of the protection afforded by one social place or nationality. In this way, Beck argues that social actors have become individualised. At the same time as the modern world has become more uncertain, contingent, flexible and risky, the processes of 'marketisation' (competitive tendering, devolved budgets etc) have served to diminish any sense of security produced by more centralised mechanisms. Gilbert suggests that

the competence to identify, calculate and manage risk is central to the trust bestowed on the professional

(Gilbert 2005 p569).

In this way, the risk society and its contingent insecurity can be seen as a mechanism for further reinforcing the power of the professional, the suggestion being that placing trust in the professional makes society feel more secure, choosing to believe that professionals are better placed to manage these risks. However, as

Gilbert suggests, within a managerialist organisation these expectations of trust and security have become “bound up with disciplinary processes such as contracts, targets and audits, many of which assume mistrust” (Gilbert 2005 p570). A whole network of interconnecting bodies: statutory, regulatory and professional have developed within the culture in order to become the ‘guardians of trust’, and so a whole industry of risk management has developed. Foucault describes the *social contract* in which people freely choose to submit to the dictates and laws of the state in exchange for its protection (Danaher, Schirato and Webb 2000).

The competence to identify, calculate and manage risk is central to the trust bestowed on professional.... Trust can be conceptualised as a component of the role of professionals... in the management of populations and themselves
(Gilbert 2005 p569)

In this way, the need for systems of quality assurance and clinical governance is created. This *Carceral* society is one which demands a self-subjugation in order to prove oneself professional (see literature review on page 100 for an explanation of Foucault’s notion of the carceral society). This is consistent with the notion of ‘soft bureaucracy’, being one in which the profession regulates quality and probity of its members’ practice in exchange for certain managerial privileges (Sheaff, Rogers, Pickard, Marshall, Campbell, Sibbald, Halliwell and Roland 2003).

Soft bureaucracy can also be seen to include the way in which professional codes of ethics, in some cases backed by legal sanctions, form a system whereby the trustworthiness of colleagues or associates is internally managed (Giddens 1990 p87).

In summary, it seems that a conflict of apparently irreconcilable demands is faced by mental health practitioners, including those involved in this study. This complex context within which the ‘professional’ practitioner needs at once to be *trustworthy*, in order to mitigate feelings of insecurity amongst their patients, as well as *self-*

regulating and *subject to* the external regulatory expectations. As St Pierre and Holmes suggest in relation to nursing:

the organisation expects nurses to be caring and professional but also subordinate

(St-Pierre and Holmes 2008 p354)

The contradiction:

1. An emerging managerialist culture, characterised by an implicit lack of trust of professional practice, and particularly the ability of professionals to monitor themselves as is traditionally characteristic of the 'professional', demands external processes and procedures to be followed, as exemplified in Clinical Governance procedures. These procedures include the practice of clinical supervision as an element of clinical governance and therefore as an agent of this external culture. In this culture, the patient/client is a consumer and the practitioner a service provider.

2. Processes of governmentality where responsibility is placed on the individual for the moral obligation to self improvement and self-monitoring which, through processes of self-subjugation, provides an internal monitoring system. In this respect, the practitioner demands of him/herself accountability towards a supervisor and surrenders significant authority to the supervisor for that purpose and yet it is the practitioner who is personally accountable for undertaking this self-subjugation, as part of their professional responsibility. In this culture, both the patient/client and the practitioner are responsible agents for the provision and receipt of care.

It would seem that participants in this study were involved in a renegotiation of their subjective positions in relation to their professions and to the contexts within which they work. Through what they said and, perhaps more significantly, through what they did *not* say, they constituted new ways of being which had both purpose and

meaning for them. They created for themselves a new space which, through the existence of unspoken boundaries, enabled them to have meaningful and purposeful conversations about their practice. In so doing, they were at once able to fulfil the external requirements of the organisation while yet also retaining their own internal integrity. Fournier (1998) describes something very similar in her analysis of Computing and Information Services' graduates and their engagement with an enterprise culture:

Subjectivities, meanings and positions created from above are likely to be re-appropriated and transformed: they are liable to tactical realignment ...
(Fournier 1998 p74)

Patient/client-centred care

An extension to the notion of governmentality is the more recent rise in what Petersen and Bunton (1997) call the 'new' Public Health, which extends the demand of self-surveillance to include not only the professional but also the service user themselves and the wider general public. It could be argued that so-called 'patient/client-centred' care and its interrelationship with prevailing ideas about the 'care of the self':

which calls upon the individual to enter into the process of his or her own self-governance through processes of endless self-examination, self-care and self-improvement

(Petersen and Bunton 1997 p194)

This actually serves the needs of a national government very well, promoting as it does the idea that individuals should take responsibility to protect themselves from risk, rather than that it being the state's responsibility to do so. This calls into question the genuine emancipatory intent of the rise in advocacy and service user groups and even recovery-based approaches to care. To some extent, these could all be said to pass responsibility solely onto the individual themselves. If this is the case and if so, the 'professional' needs to establish a new identity. Harnett and Greaney suggest that rather than patient autonomy being the aim, 'protective

responsibility' is a better way of viewing the professional role (Harnett and Greaney 2008). Whilst not relating this to issues around governmentality or managerialism, they do see it as eschewing a discredited paternalistic model of care whilst still adhering to the four principles that inform an ethical decision-making in healthcare: autonomy, beneficence, non-maleficence and justice. Whilst autonomy underlies the legal concept of informed consent, within mental health working this has to be balanced with the other principles and may not always be paramount. Referring to Seedhouse's (1998) work, Harnett and Greaney argue that autonomy has to be created, not simply respected and is not entirely synonymous with granting patients absolute choice. In this way, the patient is not just a 'consumer' but internally directed, by engaging in self-care.

Risk and experiment-welcoming forms of supervision

This emerging discourse on the involvement of the service user in the delivery of their care provides a potential opportunity for a broadening of the framework of supervision. Rather than attempting to reconcile conflicting positions around the role of supervision as a mechanism of public safeguard, perhaps this wider discourse on the agency and active involvement of service users provides instead the opportunity for supervision to become a place where new kinds of relationships with service users can be explored. This would have implications for the traditional structure of supervision, being one where the service user is at the centre of the discussion but not actually present, an anomaly identified well over a decade ago by Mearns in his article, *Supervision: a tale of the missing client* (Mearns 1995). Perhaps the space is now beginning to open up where new formats of supervision can be explored – ones where service users themselves are able to take an active part as a partner in their care. This would be consistent with the wider emerging discourse on care, outlined in the literature review on page 103 under an exploration of the changing nature of care but would require a new engagement with the discourse around risk:

There is a need to explore the extent to which mental health organisations are prepared to learn from their mistakes and learn about learning. There is a further need to move towards risk and experiment-welcoming forms of clinical supervision which should mirror recovery-based, needs-led approaches to care.

(Grant and Townend 2007 p614)

Whilst this would involve a review of the discourse of *supervision as safeguard*, as it would become a riskier place, the potential for introducing new and innovative ways of working could not be more timely, as practitioners are facing constantly and rapidly changing expectations in terms of their ways of working.

The ‘professionals’

The professions represented in this study have a particular commitment to psychosocial processes, being situated within those very disciplines responsible for the extended clinical gaze described above. Despite this shared commitment, it is important not to view all three as a homogenous group. On the contrary, as detailed in the review chapter on the discourse of the professions on page 92, there is substantial variation between the way these professions see themselves and the way they are perceived both within and outwith their professions. Whilst psychology has traditionally been viewed as a relatively high status, specialist profession and nursing as well-respected and deeply embedded in our cultural history, counselling continues to struggle to assert itself as a profession. Even amongst counselling practitioners themselves, there is disagreement as to whether counselling should be regarded alongside nursing and psychology as a ‘health profession’. Hansen argues strongly that counselling should not be viewed as such, arguing that health professions *per se* draw heavily on the medical model which counselling generally eschews (Hansen 2007), hence its resistance to the term ‘clinical’ supervision. Of course, Hansen’s argument is not that counselling should not be considered a profession at all, far from it, he recommends that it should be considered a ‘human service profession’ such as law, accounting and education (Hansen 2007 p9). In fact, each of these is a much

older and more established profession than many health professions, though this is not Hansen's expressed reason for aligning counselling along with them.

These differences in professional identities across the professions inevitably influences the way each views the contexts within which they work and their responses to external constraints and expectations. For example, faced with potential changes to the configuration of psychological services, the psychology supervisor remarked:

9420: I think the [place the] profession has had in relation to other professions, and the complacency that I think it has felt in relation to what it does will all have to change. ...it would be imperious and arrogant to suggest that that might not be a good thing

The analysis in this study suggests that the participants felt a strong commitment to their own professions and took their perceived responsibilities seriously in terms of maintaining their own profession's values and aims. However, in light of the discussion about the changing nature of the 'professional' combined with current realignments and convergence of professional roles in mental health practice it is probable that this discourse will be submerged into the more dominant discourse of *supervision as safeguard*. It is still, however, an open question.

Supervision as nourishment: a new formulation?

The proposed additional discourse as identified in the analysis is that of *supervision as nourishment* which potentially provides the possibility for the emergence of further new ways of thinking about supervision.

Analysis of the data suggested that participants valued this as a discourse:

3310: that felt quite good.....that felt really good as well, to talk about other ways the service could go. So it felt good at simply talking to somebody who really had their finger on the pulse with that, if you like...I am always left, or usually left I should say, with a sense that there is not enough time in supervision because supervision is inherently rewarding... So you are left

with this sense of well you know, it doesn't matter what I bring, they are going to have something useful to say.

(Counselling supervisee)

Like a good workout:

3263: it is a bit like being a dog on a lead, one of those leads where it just extends out and out and out. So the dog feels as though he is having a good run around, but at the same time somebody... somebody is gently walking around the field.

(Clinical psychology supervisee)

As recognised in the literature review on page 73, there is evidence that supervision can be a vehicle for reducing stress and burnout and therefore ease staff retention and recruitment issues. (Severinsson and Borgenhammar 1997; Tilley and Chambers 2003; Hyrkas 2005) This suggests that supervision is seen as a means by which a practitioners' energy can be renewed and resources maintained. Mearns talks about the "nutritious nature" of counselling supervision" (Mearns 1995 p421).

On returning to the discourse of the professions with this in mind, there are just one or two hints of the possibilities for this new discourse emerging. For example, in my telephone conversation with the supervision lead at the Division of Counselling Psychology, as quoted in the third section of the literature on page 120, she referred to:

the existence of 'vast amounts' of anecdotal evidence from practitioners that supervision helps them think through complex situations and makes them more efficient practitioners and keeps them healthy.

(Supervision Lead DCP)

And in the opening sentence of Information sheet provided by the British Association for Counselling and Psychotherapy:

Counselling relies heavily on the emotional health and development of its practitioners, and it is supervision which monitors and serves to maintain that health

(Mearns 2004)

Linking supervision with discourses of practitioner 'wellbeing' may provide a new opportunity to reframe the nature and purpose of supervision within the emerging discourse of the healthy workplace, and is provided in the recommendations of this thesis as a potential space for the development of new frameworks around the practice of supervision.

Having discussed the research participants' engagement with the identified dominant discourses in relation to Foucault's notions of power and knowledge, some tentative conclusions can be drawn and this is the focus of the next, and final, final chapter.

Chapter nine: Conclusion, limitations and recommendations

Introduction

This final chapter is divided into three sections. After drawing some conclusions, an analysis of the limitations of this study will be explored. Finally, some recommendations for future practice and research will be proposed.

Conclusion

At the end of this Foucauldian discourse analysis of supervision in mental health practice, six conclusions are drawn, including the proposal of a new framework for supervision. A summary of these conclusions is provided at the end of this section, on page 232.

Assumptions about the nature of supervision

Throughout this thesis, criticism has been levelled at the large quantity of literature which fails sufficiently to articulate its cultural, professional and contextual dimensions. Whilst it is entirely understandable that writers seek to appeal to as wide a range of readers as possible, the effect of this lack of clarity has contributed to an ongoing conflation of assumptions around the nature and purpose of supervision. This is perhaps most profoundly evident in the persistent lack of regard for the critical difference between supervision within a training environment and supervision with an ongoing professional environment. As there is no culture in North America of post-qualifying supervision, assumptions and recommendations deriving from the American supervision literature necessarily focus on the learning, teaching and development potential of supervision. To assume these are also necessarily central to post-qualifying supervision is a mistake. Whilst participants in this study certainly

draw extensively from the *supervision as development* frame, the very lack of any questioning of its developmental purpose results in insufficient critique of its potential weaknesses.

This lack of critique is also apparent in the tacit assumption that reflective practice is a requisite element of both supervisory conversations and professional practice itself. Despite convincing arguments in the literature about the potential for an emphasis on reflective practice to be a pervasive form of self-subjugation and thereby a system of self inflicted surveillance, professional discourses continue to assert the benefits of reflective practice as a means of developing an autonomous and capable practitioner. Participants in this study did not question either the professional or personal benefits of reflection. Once again, this tacit acceptance leads to a lack of critique of a basic assumption about the nature and purpose of supervision.

Similarly, participants drew from the *supervision as containment* framework quite comfortably and did not question the 'holding' nature of the supervisory relationship. What did emerge through the discourse, however, was the existence of murky edges around the boundaries of that holding capacity. These 'bouncy castle boundaries' appeared to relate both to the limits of the confidential nature of the relationship and to the kinds of topics that could be spoken about in supervision. One of the murkiest boundaries of all was that between supervision and therapy. But this should perhaps not be a surprise. Due to its history in the therapeutic tradition not being explicitly recognised (either in the literature or in the empirical data), attempts to draw from its discursive frame whilst eschewing its inherent therapeutic intent is contradictory. If the value of the containing nature of supervision itself could be challenged then the debate about the relationship between supervision and therapy could be more comprehensively re-evaluated.

One further assumption identified and reiterated in much of the supervision literature is that research into supervision lacks sufficient rigour and therefore evaluations have been unable to draw any significant conclusions. This assumed lack of rigour is cited as one possible reason for an apparent lack of commitment to the practice of supervision, particularly in nursing. The problem with this assertion is that it largely derives from a positivistic paradigm. And this, in itself is probably due to disciplinary hierarchies within health. In a culture where the discipline of medicine, with its continuing headlining of the randomised control trials as the research gold standard, retains the highest status as a profession, the newer and aspiring health professions can find themselves striving to gain acceptance by ascribing to a similar paradigm. This is most noticeable in the psychology literature, though not exclusively. Whilst this may have positive benefits in terms of the profile of the profession in general, it has unfortunate consequences for research in health, not least research into supervision in health. Others have argued for the acceptance of a broader research paradigm which more effectively explores the complexity of the human sciences and there is hope that the hegemony of the positivistic research paradigm is beginning to erode.

Professional and cultural contexts

Despite considerable attention in the professional literature with respect to expectations about the delivery and engagement with supervision and its relationship to governance procedures, this study suggests that the practice of supervision is a very personal experience. Very few connections were made to wider professional concerns, raising questions about the role of supervision in inducting the new practitioner into his/her profession. Where connections to the wider professional and cultural contexts were discussed, these were in the context of strategising ways of managing and containing the demands and constraints they risked imposing.

In the rapidly changing external environment which characterised the context of this study, participants were active in making personal meaning for their practice, suggesting that supervision is, for them at least, a place where external constraints and expectations can be weighed in the light of personal and professional values.

A new framework for supervision

The three dominant discourses of supervision identified in this thesis provide in themselves a way of conceiving the nature and practice of supervision which is not constrained by context or profession. Each one of them crosses these traditional boundaries and therefore can provide a broad and inclusive framework for the practice of supervision in a variety of contexts and professions. However, only in recognising and articulating the histories and theoretical underpinnings of each can they be adequately critiqued and reassessed. They need to be critiqued as there are problems inherent with each. For example, as argued above, the discourse of *supervision as containment* relies on the acceptance of a power imbalance between the container and the contained, in which the container must be strong enough to (with)hold its contents and, similarly, the contents must make themselves subject to the shape and capacity of the container. In this way, viewing supervision as containment perpetuates the 'expert'/'novice' model of the supervisory relationship and inhibits the development of other kinds of relationship: ones that would perhaps be more consistent with the shifting balance of power relationships within mental health practice itself. The rise of service user groups and the expert patient movement have gone some way to decreasing the power imbalance between carer and cared-for (notwithstanding concerns about Foucault's insights into the docile body and the localising of responsibility of care). A re-evaluation of the nature of *supervision as containment* might open up space for a similar realignment of power between supervisor/expert and supervisee/novice.

In a similar way, it is important to keep the aspects of *supervision as development* and *supervision as safeguard* under review, particularly in light of ongoing changes to both training and regulation requirements.

This study has identified a further potential discourse: *supervision as nourishment*. There is literature which explores the role of supervision in reducing stress and burnout, though this is largely in the context of managerial concerns over retention issues. Further exploration is needed into this aspect of supervision as it creates the opportunity for a new way of looking at the nature and purpose of supervision: rather than being a forum for learning, reflection and professional development which itself is potentially stressful, perhaps it could be conceptualised as an essential aspect of occupational health. It would certainly be consistent with the recent development in ideas about healthy workplaces (NHS 2009). This needs much further investigation and is offered here as a potential new way of framing the practice and benefit of supervision and opens up possibilities of new ways of working.

Wider issues in mental health practice

This emergence of self-regulation can be seen to extend beyond professional practice and in the mushrooming of self-help movements and therapies. Armstrong {, 1993 #3} suggests that the twentieth century saw the individual as constituted as a more active, physical and social being who needs to become their own self-practitioner. This can perhaps be identified within the service-user movement and the recovery approach in mental health:

With such a current focus upon risk in western society, it is virtually inconceivable that statutory healthcare providers will ever fully embrace the recovery paradigm that involves self-management and has choice, freedom and autonomy at its core. Furthermore, these values are extremely difficult to measure in a system that revolves around targets and outcomes
(Bonney and Stickley 2008 p150)

Emergence of new ways of working with patient-centred care and, particularly service user involvement, raises serious questions over the future viability of a practice like supervision in which the subject of the conversation (the client/patient) is absent (Mearns 1995).

Foucault's discourse analysis as a method to explore supervision

Foucault's method of discourse analysis, based on his 'genealogy of the present' methodology, which concentrates on the forces and relations to power connected to discursive practices ((Hall 2001; Stevenson and Cutcliffe 2006) which seek to *describe* rather than *interpret* the various discourses and the way they are presented, has proved extremely challenging. Nonetheless, it has enabled the identification of challenges and opportunities for the practice of supervision, which have been relatively unexplored through alternative research methodologies. It has raised more questions than it has answered and means that this thesis feels incomplete. There is so much more to be explored in the light of Foucault's insights, particular in relation to the productive nature of power and the implications to contemporary mental health practice of the concept of surveillance and the docile body.

Summary of conclusions

1. Much of the literature to date has failed sufficiently to question basic assumptions about supervision. With some notable exceptions, it tends to assume that supervision is a 'good thing' despite claims of a dearth of rigorous research and evaluation studies. Inadequate interrogation of these assumptions leads to an uncritical acceptance of them and the implications in terms of power relations and possibilities of the supervisory encounter.
2. Three dominant discourses of supervision have been identified in the literature: *supervision as containment*, *as development* and *as safeguard*.

Articulating the histories and dimensions of these discourses facilitates a new way of conceiving of the multi-dimensional potential of clinical supervision and conceiving of them in this way may be useful as the basis of a new, cohesive frame which integrates a range of models and approaches.

3. Rapidly changing cultural and professional contexts seek to shape the nature and practice of supervision through regulation and governance procedures, drawing extensively from limited dimensions of a discourse of *supervision as safeguard*. However, practitioners demonstrate considerable resistance to these demands.
4. Practitioners draw from additional discourses in talking about their practice, particularly *supervision as nourishment*. Consideration of this aspect of supervision may open up opportunities for new ways of thinking about and practising supervision as a mechanism for supporting practitioner 'well-being'.
5. Recent developments in mental health practice towards person-centred care, patient autonomy, a recovery-based approach and the rise of service user participation are consistent with Foucault's notions of governmentality, the docile body and self-subjectivity. In emphasising the agency and autonomy of the service users him/herself these movements can be seen to be collaborating with a society that requires the self-regulation and self-monitoring activities epitomised by Bentham's Panopticon. Further discursive analyses of these developments would offer the opportunity to critique the meanings, sites of knowledge and power relations which underpin these practices and, importantly, the implications for the practice of supervision where the focus of the conversation, the service user, is excluded.

6. Foucault's approach to discourse analysis is a relevant approach with which to explore basic assumptions around the nature and practice of supervision, as it seeks to critique the *roots*, *rules* and *systems* that govern the discourse at the individual and localised level, which is where supervision is played out.

Limitations

A number of limitations can be identified in this study. These are identified below in terms of the limitations in relation to:

- Applying Foucault's approach
- The study sample
- The longitudinal aims of the study
- The Complex map of supervision research
- The challenge of Keeping pace with changing policy

Applying Foucault's approach

The lack of a clear application deriving from Foucault's approach to discourse was highlighted as the main criticism of his approach in the methodology chapter on page 26. Whilst this provided the opportunity to develop a unique application of the approach, consistent with the aims of this study, it also meant that this had to stand alone and could not be justified through reference to previous applications and research. The need to provide a transparent decision trail was therefore critically important to provide the necessary methodological rigour. Yet the nature of the study, iterative and developmental, meant this was a constant challenge and one which I hope has been largely successful.

The early identification of dominant discourses and the retrospective application of this frame onto the empirical data inevitably placed constraints on the way in which I read and interpreted that data. Whilst this subjectivity is entirely justifiable within the methodological approach, it is nonetheless risky as I needed consistently to make and then trust my own judgements. I identified in chapter three (on page 21), that there are many different Foucaults and many different readings of Foucault (Parker 1995; Armstrong 1997 p15).

A further risk associated with the early identification of dominant discourses is that other discourses, perhaps subdominant ones may be obscured or missed. However, the intention was never to undertake a thematic analysis so there was not a methodological need to justify saturation of themes.

The study sample

The original intention for this study was to include a larger number of case studies but the quantity and breadth of the professional literature required a rationalising to the eventual three case studies. Whilst this enabled a comprehensive review of the literature relevant to each, the exclusion of other key professions, particularly social work and medicine is a limitation in that it precludes a range of literature and insights from these professions that may have contributed to the development of the discursive frame. This decision also limits the contribution that the findings can make to the current context of multidisciplinary working.

The small number of case studies also necessitated a determination to resist any temptation to draw conclusions about generalisable characteristics of specific professions. It would have been very attractive to be able to make some claims about the current state of supervision within an entire profession, but that would have required an entirely different methodology.

Longitudinal aims of the study

One of the original aims of this project was to maximise the opportunity to explore changing practice over time. The plan was to start the study with newly qualified supervisees and to track their supervisory experience across three years. I was hopeful that this would provide an insight into how the supervisory relationship itself develops with increasing experience. As indicated in the literature review on page 89, this is an under-researched area, and I was keen that this project should provide a contribution to that. However, in reality, recruitment to the study from mental health nursing was problematic and delayed and in the event I was grateful for the participation of more experienced practitioners. This meant that only two of my initial supervisees were newly qualified. In addition, none of the partnerships sustained throughout the duration of the project. This unfortunate but unavoidable lack of continuity of participants meant that I was unable to say anything meaningful about longitudinal change as planned.

Complex map of supervision research

The literature review identified a complex range of literature and research into the practice of supervision. One of my main critiques of supervision research was its frequent lack of clarity in terms of its espoused research paradigm. However, in introducing an original methodological approach in this study, it could be argued that I have increased, rather than decreased, that complexity. However, my intention throughout has been to demonstrate that a rigorous study can be undertaken which both embraces complexity and difference while still be able to generate some interesting and innovative findings.

Keeping pace with changing policy

Work on this thesis began in 2004 and literature for the comprehensive literature review was largely compiled in 2005. In a context in which policy and practice is changing faster than ever before, five years is a long time and the arrival of the coalition government in May 2010 has brought with it another swathe of policy changes, the details and implications of which are yet to be fully known. This inevitably means that the currency of the findings and recommendations of this study are already under threat. It is hoped, however, that it can provide a historical base and trail on which future policy and practice changes can be built.

Recommendations

In making tentative recommendations in light of the outcomes of this study, it is essential to recognise its localised and context-specific nature. Whilst a very large range of literature was reviewed, its interface with practice was limited to an in-depth exploration of the discourse of only six participants in one county of the UK.

Consistent with the theoretical perspectives that have underpinned the entire study, the focus has intentionally been on localised systems and individual interactions. In this way, any attempt by me to generalise these findings to other contexts would be entirely inappropriate. Nonetheless, I have attempted to provide a transparent account of the process and the participants involved, distinguishing at every opportunity between the individual, the professions and the contexts.

The explicit intention in taking great care over this was in order to make only appropriate recommendations. Any application to other contexts must be undertaken with great caution and with due recognition of the differences of context. They are offered purely as an invitation to further conversation about possibilities for the practice of supervision, or other endeavours which enable those working within the

field of mental health to develop and maintain interesting, creative and sustainable practice.

In light of this caveat, the following are offered as tentative recommendations for consideration, to:

1. Continue to critique and question basic assumptions about the 'goodness' of supervision and the consensus around its constituent aspects. Take nothing as a 'given'.
2. Take a critical approach towards the genuinely emancipatory potential of reflective practice within supervision.
3. Consider opportunities to reconceptualise the practice of supervision, through the emergence of new discourses so it might be seen as a means to support and maintain well-being.
4. Engage in a wide range of research paradigms in investigating supervision, but ensure that studies are rigorous in order that assumptions about what counts as good research can be robustly challenged.

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Appendix one: interview protocol

Interview to follow as soon after the recorded supervision session as practicably possible

Interview to last approximately one hour
Introductory comments:

Thank you for giving this time to reflect on the supervision session that you have recently undertaken and recorded. This is an opportunity for you to reflect on what took place. I have a few things that I'd like to ask you about, but I'd like you to feel free to explore the session in any way that you would like to.

I shall be recording this interview onto minidisk.

What are your initial thoughts and feelings about the session?

[The following are possible questions depending on the content of the session and how it develops]:

What went well?

Why do you think that was?

What didn't go so well?

Why do you think that was?

What do you think was the most significant exchange in the session?

What was significant about it?

How would you describe the kind of supervision that you gave/received?

How does that relate to your theoretical understanding of supervision?

Did this session conform to your expectations?

In what ways?

What documents and/or literature do you use/have you used to inform your understanding of supervision?

What do you think are the critical aspects of good supervision?

What makes you say that?

What can hinder good supervision?

Do you like supervision?

What makes you say that?

Is there anything else about this session in particular, or about supervision in general, that you'd like to say?

Appendix two: participant invitation letter

Dear Colleague

Re. PhD Research Project: Supervision in Mental Health Professions

Are you involved in providing or receiving clinical supervision in your professional role?

Have you ever considered whether the supervision you give and/or receive is the same as that of others, either within your own profession or in other professions that also practise supervision?

In a professional climate where we are increasingly asked to increase the effectiveness of inter-professional communication, even to work in multi-disciplinary teams, it seems crucial that we develop our understanding of the practice of supervision; to discover where good practice occurs and what makes it good; to challenge, if necessary, accepted norms of what constitutes effective supervision within and across professions; and, above all, to foster mutual understanding and respect between professions working in mental health.

If you are interested in these themes and you are currently involved in a supervisory relationship, either as supervisor or supervisee, with one of the professions of **counselling, mental health nursing or clinical psychology**, then I would love to hear from you.

I would hope that your involvement in the research will provide an opportunity for you to reflect on your practice in a structured, supported and ongoing way, which will be of benefit to your own professional development.

If you're still interested, I'd be grateful if you could make contact with me at helen.bulpitt@btinternet.com as soon as possible.

With many thanks for your interest and I very much hope to be able to work with you.

Yours faithfully

Helen Bulpitt
PhD Student
Department of Health and Human Sciences
University of Essex

Appendix three: participant's information sheet

Title of this research study: Supervision in Mental Health Professions

You are being invited to take part in a research study. Before you decide whether to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Please ask if there is anything that is not clear or if you would like more information and take time to decide whether or not you wish to take part.

Who is conducting the research?

The research is being conducted by Helen Bulpitt, and undertaken for the PhD Health Studies in the Health and Human Sciences Department at Essex University.

What is the purpose of the study?

The project is being undertaken to explore what supervision means and how it is practised within a number of professions working in the field of mental health. It will seek to explore the areas of difference and similarities between the professions in an attempt to foster better mutual understanding and interprofessional working. It will also consider whether supervision is a useful experience in achieving its aims of professional development, monitoring of quality of provision, and service-user safety. The study aims to follow a number of supervisory relationships and explore the nature of the supervision that takes place.

Why have I been approached?

You have been approached because you are currently active within a supervisory relationship, either as a supervisor or supervisee within one of the professions of counselling, mental health nursing or clinical psychology.

Do I have to take part?

No, participation in this research is purely voluntary. It is up to you to decide whether or not you wish to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time, and without giving a reason.

What will happen to me if I take part?

You will be invited to record one of your regular supervision sessions. Shortly following this session, you will be interviewed on your own by the Chief Investigator (HB) who will ask you to explore your experiences of the preceding session, including what you thought was happening and why. You will also be asked which documents and/or literature you have read or used which has helped you to understand your role in supervision. A similar pattern of a recorded session followed by an individual interview will then be repeated in the autumn of 2008.

What are the advantages and disadvantages of taking part?

It is hoped that your involvement in the study will greatly support you in your professional development, giving you the opportunity to reflect on your practice and monitor the development of your supervisory relationship over time, with only a minimal time commitment. Although a guarantee of your involvement throughout the three year period is not expected, it is hoped that your interest in the topic and in your own development will enable you to maintain your involvement throughout the length of the project.

Will my taking part in this study be kept confidential?

If you consent to taking part in the research, any information that is collected about you during the course of the research will be kept strictly confidential. Only Helen Bulpitt, the Chief Investigator, will have access to information that may identify you. All interview data will be given a numerical code with identifying details removed so that you cannot be recognised from it. All information will be kept in a secure site.

What will happen to the results of the research study?

The results will be used primarily for the academic dissertation. It is hoped that they may be published in relevant academic journals and /or presented at professional conferences in the future. If you wish in due course to obtain a copy of the published results, please ask Helen Bulpitt. Any information that could be used to identify you will be removed from the dissertation and any ensuing publications.

Who is organising the funding for the research?

The research is not being directly funded. Essex University is, however, sponsoring the investigator's doctoral course.

Who has reviewed the study?

The study has been reviewed by the North and Mid Essex Local Research Ethics Committee, the North Essex Mental Health Partnership Research and Development Committee as well as the Academic Supervisor.

Contact for further information:

Helen Bulpitt
helen.bulpitt@btinternet.com
 c/o Department of Health and Human Sciences,
 University of Essex
 Wivenhoe Park
 Colchester
 CO4 3SQ

Thank you for reading this information sheet and for considering participating in this study

Appendix four: participant consent form

Title of the Project: Supervision in Mental Health Professions

- I can confirm that I have spoken to Helen Bulpitt about this research study.
- I understand that my participation in this research study is voluntary and that I may choose to withdraw at any time without giving a reason.
- I have read and understood the information sheet dated 14/03/2013 for the above research study, and have been given sufficient time to consider this information and discuss it with other people not involved in the study.
- I confirm that I have been given enough information about the study and I am satisfied with the answers given to any questions I have asked about the study.
- I agree to take part in this study

Name of Participant:

Signature:

Date:

Name of person taking consent:

Signature:

Date:

Appendix five: data transcript line numbers

Interview	Lines from	Lines to
Counselling supervision session one	1	805
Counselling supervisor interview one	806	1343
Counselling supervisee interview one	1344	1640
Clinical psychology supervision session one	1641	2594
Clinical psychology supervisor interview one	2595	3165
Clinical psychology supervisee interview one	3166	3699
Mental health nursing supervision session one	3700	4667
Mental health nursing supervisor interview one	4668	5321
Mental health nursing supervisee interview one	5322	5800
Counselling supervision session two	5801	6699
Counselling supervisor interview two	6700	7524
Counselling supervisee interview two	7525	8043
Clinical psychology supervision session two	8044	8928
Clinical psychology supervisor interview two	8929	9591
Clinical psychology supervisee interview two	9592	10202
Mental health nursing supervision session two	10203	10816
Mental health nursing supervisor interview two	10817	11288
Mental health nursing supervisee interview two	11289	11718
Counselling supervision session three	11719	13112
Counselling supervisor interview three	13113	13450
Counselling supervisee interview three	13451	13961
Mental health nursing supervision session three	13962	14486
Mental health nursing supervisor interview three	14487	15131
Mental health nursing supervisee interview three	15132	15527